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the JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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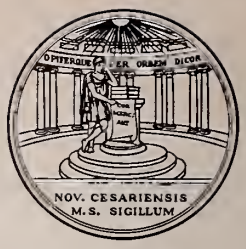
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EDITORIALS

Physician's Role in Treating the Alcoholic

While we all give lip service to the idea that alcoholism is a disease, not a crime, most of us don't act as if we really believed this. It is of interest to note that our last House of Delegates resolved that "alcoholism detection clinics be established in every county in New Jersey and that each county medical society take leadership in endorsing, encouraging, and participating in such clinics."

On page 19 of this issue we publish a pioneer article on prevention of alcoholism. This offers a practical operational guide to the physician who seriously considers his responsibility to the alcoholic patient. One thing is sure. If we doctors of medicine do not assume this leadership, other professional groups will rush into the vacuum. As Dr. Shenkman points out in his paper, it takes ten years or more for alcoholism to develop fully, and this offers time for early detection and prevention. It is working with cancer of the cervix and with diabetes, and should also be possible in alcoholism.

The Other Side of the American Medical Image

In the past eight years nearly 125,000 of Europe's best educated young people have in one way or another sought admittance into the United States. These include physicians in search of high-quality advanced education and the right to work unfettered by unacceptable restrictions. Not finding it in their homelands, they turned to the United States. Only a fraction of the 15,000 hopeful young doctors seeking entry each year ever arrive here. Figures of the Association of American Medical Colleges show that of those who take the Educational Council for Foreign Medical Graduates' examination, only about one-fifth are accepted. This means that about 4,000 are arriving from Europe annually to work and study in medical schools and hospitals. And a large number of these are staying to practice medicine. To Europe, this loss has helped create the "brain drain."

Medicine is not the only branch of science involved in the "brain drain." Europe is also losing engineers, chemists, and physicists. The implications of the flight of its young scientifically educated has European leaders worried. There is concern that the continent has become undeveloped scientifically and technologically in comparison with the United States. What's more, the gap is growing.

In Great Britain, the emigration of its young physicians has threatened Britain's National Health Service with collapse. They complain that about one-third of Britain's medical graduates are leaving the country each year. And, the number of medical students going into training has been falling steadily.

An eminent barrister, R. H. Davison, told the British Medical Journal that: "Not only has the NHS provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession who see through its Fabian Humbug." He noted that even the supply of doctors being imported from Pakistan and India to help fill the vacuum of British doctors was dwindling, and criticized the government suggestion that, "the advent of the Common Market will permit us to import Italian doctors to run our Health Service."

The tempo of emigration from Britain has accelerated despite government efforts. One emigrating doctor put it this way: "We're not exactly forced into servitude by the government; but we're not exactly free to practice our profession either. You in America still have a choice. But what would happen if that choice were removed as it has been in En-

rope? Where would American doctors emigrate?"

What has caused the drain of European brains? Partly it is money. Britsh interns say they work an average of 100 hours a week for less than $200 a month. That figures out to about 45 cents an hour. But the greater issue clearly is one of "scientific climate." Over-regulated conditions have served to stymie scientific inquiry; without scientific inquiry there is lack of stimulation; and without stimulation scientific advancement suffers. So goes the analysis of what's wrong with science in Europe.

This, of course, is an over-simplification. But the fact is that the young, scientifically-oriented have shown by their desire to vacate Europe that something about the scientific climate there is inadequate, if not stifling. And whatever it is, the medical school graduates of Europe have turned to the United States to get into the mainstream of medical science.

American medicine became a lure to European doctors following World War II, when the United States emerged in the forefront of medicine. Obviously, the United States has continued to better its standing. If this were not so the brains of Europe wouldn't be seeking entry. For they crave scientific excellence along with freedom to practice their profession.

Since World War II, twenty-three Americans have been awarded the Nobel Prize in medicine and physiology. That's more than were won by physicians and scientists from all of the other countries of the world combined. In the same period, well over half of all the major new drug discoveries were developed in this country. As a matter of fact, eighty per cent of the prescriptions written today could not have been written ten years ago because the drugs didn't exist.

But medical progress cannot be measured only in the laboratory. It must also be measured in terms of people, disease, and facilities. Thus, the fact that America was building 750 hospitals in the same time that England was building one enters the picture.

So do such matters as the rate of death from various diseases. The death rate from cancer in America, for example, is well below the rate of Western Europe. This reflects better medical treatment. The same holds true for other treatable diseases, including tuberculosis, pneumonia, strokes, and influenza. All of these kill fewer people here, per capita, than in Western Europe. What it all adds up to is this: four and a half million Americans alive today would be dead, if medicine were practiced with the same amount of knowledge and the same tools as it was just twenty-five years ago. In that time span medicine has learned more than it learned in the previous fifty centuries.

No one can assign a nationality to such knowledge. It is world wide. But when it comes to teaching and applying that knowledge, the rest of the medical world looks to the United States for leadership.

Not All Health Is A Medical Problem

Perhaps it is odd for our profession to say this, but actually not all health is a medical problem. There are places where poor nutrition leads to poor health, where bad sanitary engineering spreads disease, where persistent cigarette smoking leads to emphysema, cancer of the lung, and peripheral vascular disease, where drug abuse is raging, and where people are killed or maimed by automobile accidents. The physician has practically no meaningful control over these hazards. So, when it is pointed out that diseases and injuries do seem to occur in a field where they *could* be prevented, let it be remembered that the causative factors here are not really medical problems at all. We are flattered at the implication of our potency—that we can solve all these problems just by good will. But that, alas, is not how it is.

ORIGINAL ARTICLES

Accurate diagnosis is the key to genetic counseling, as Professor Kushnick here explains.

Genetic and Chromosomal Abnormalities in Early Infancy*

Theodore Kushnick, M.D./Newark

Careful examination of the newborn and young infant can lead to the detection of a surprisingly large number of physical abnormalities. Most of these conditions are solitary and minor, being frequently inherited through the small effects of multiple genes interacting with the environment; i.e. multifactorial inheritance. Some 10 to 13 per cent of newborns will have such single minor malformations. At this point, however, it is necessary to emphasize that infants who have genetic errors of biochemical metabolism, other than endocrinopathies, usually appear completely normal at birth. Only 1 per cent of the newborn population will have major gene defects. While this group includes the normal-appearing infants with metabolic errors, it also contains the large group of children with multiple minor and major malformations that comprise various genetic malformation syndromes. Some 1500 to 2000 diseases fall into these categories. Their distribution between dominant and recessive inheritance patterns is nearly equal, the former slightly more prevalent. Although the number of disease types is large, the incidence of each particular disease is very low to rare.

The multiple minor and major malformations with chromosomal abnormality are less frequent and are found in only 0.5 per cent of the newborn population.

Intrauterine environmentally-caused defects, e.g., congenital rubella syndrome, occur at varying rates and are dependent on the prevalence of infectious disease or teratogenic drug epidemics, with an average incidence of up to 1.5 per cent .

Detection of minor malformations does provide clues as to the probabilities of underlying major malformations and this leads to the diagnosis of *major* genetic and chromosomal syndromes. However, exclude *familial* minor conditions, e.g., syndactylism between the second and third toes, from the *new* occurrence of the condition in a particular infant. Over-all, if no minor malformations are detected, there will be a 1.4 per cent incidence of usually single major malformations. Of the 10 to 13 per cent of newborns with one minor malformation, 3 per cent will have an additional major abnormality. Only 0.8 per cent of the newborns will have two minor defects and, of this group, 11 per cent will have a major abnormality. When we deal with the 0.5 per cent of the newborns that have three or more minor defects, there is a 90 per cent chance that they also have a major malformation of the brain, heart, kidney, genitalia, or gastrointestinal tract. Thus, it is in the latter two groups that extensive investigation becomes necessary and should include special x-ray studies, e.g., intravenous pyelogram; as well as chromosome analysis; tests for evidence of intrauterine infection; genetic pedigrees for syndromes; and, in some instances, particular biochemical tests.

The physical defects that are sought for on

*Read before the Sections on General Practice and Pediatrics, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 17, 1971. This work is from the Department of Pediatrics, Martland Hospital Unit, CMDNJ at Newark. Dr. Kushnick is Professor of Pediatrics.

examination are quite numerous and varied. Any *one* of them might be found in normal individuals, but a high risk of genetic or chromosomal aberrations exists when they are present as multiple findings in one individual. Conversely, while numerous stigmata are searched for in a condition such as Down's syndrome, there is no *one* abnormality which is found in *every* afflicted individual. Most of the following stigmata are of minor nature, but some may be classifiable as major. Determine if there is evidence of intrauterine growth retardation, i.e., small-for-dates baby, since many syndromes do present as low birth weight babies in relation to gestational age. Thus, length, weight and head circumference must be measured and compared with the norms. Other physical aspects follow:

Skin: The skin should be examined for hemangiomata which are found in 13 trisomy and in partial deletion of the short arms of one #4 chromosome (4p-). Petechiae are common with intrauterine infections as well as in erythroblastosis fetalis due to Rh incompatibility.

Head: Look for size and shape. Microcephaly is frequent with chromosomal abnormality and intrauterine infections. The latter can also lead to hydrocephalus. A low posterior and lateral hairline can be found in Turner's syndrome. The occiput is prominent in 18 trisomy, while the forehead is sloping in 13 trisomy.

Eyes: Hypertelorism or hypotelorism are important clues to abnormalities of genetic or chromosomal origin. Measurements for normal spacing of the eyes have now been defined for various age groups and can be used for comparison. Epicanthal folds may be found in the normal baby or exaggerated in Down's syndrome. The outer slant of the eyes is upward in trisomy 21 and downward for various genetic syndromes and partial autosomal deletions. Defects of the iris or eyelids may define certain genetic syndromes such as Rieger's or Treacher-Collins'. Brushfield spots in the iris are best seen in the newborn with Down's syndrome and tend to dissappear as he grows older and as his eye color changes. Microphthalmia and eyelid ptosis are prominent in 13 trisomy and Turner's syndrome respectively. Bulbar conjunctival tumors may be the clue to the presence of the oculo-auriculo-vertebral syndrome. Cataracts and chorioretinitis signify the presence of intrauterine infection such as rubella and toxoplasmosis.

Ears: The ears should be examined with regard to being low set (i.e., the tops below the level of the outer palpebral fissures). Are they deformed, large, or small? Note if there are preauricular tags or sinuses. What is the degree of posterior rotation from the vertical axis? Check hearing, if feasible.

Nose: Noses come in all sizes and shapes but their appearances can be significant for certain syndromes, e.g., the anteverted nostrils of the de Lange syndrome; the small depressed nasal bridge of Down's syndrome; the large non-angulated nose of Treacher-Collins' syndrome; the single nostril; the cleft nasal cartilage in the median facial cleft syndrome; or the septum extending below the nostrils in Rubinstein-Taybi syndrome.

Mouth: Mouth abnormalities include micrognathism, which accompanies many syndromes; cleft lip and/or palate as found in 13 trisomy; glossoptosis with Pierre-Robin syndrome; the abnormal shape and size seen in the whistling-face syndrome; and the Treacher-Collins' syndrome. Macroglossia consistent with Beckwith syndrome may be present. The baby's cry should be listened to in order to detect the cri-du-chat 5p- syndrome or the coarse cry of the cretin.

Neck: Determine whether the posterior cervical skin is redundant and loose, with or without webbing, and whether the neck is short. Webbing is found in Turner's syndrome and other chromosome abnormalities, as is loose posterior cervical skin.

Chest: Besides noting the presence or absence of a cardiac murmur, the detection of a short sternum indicates a possible 18 trisomy; wide-

ly spaced nipples and pectus excavatum might be correlated with Turner's or Noonan's syndrome. X-ray examination of the chest may reveal absent and/or hypoplastic ribs which are found in 13 and 18 trisomy.

Abdomen: Diastasis recti and umbilical hernias are frequent findings in Down's syndrome and congenital hypothyroidism. A determined effort should be made to palpate the kidneys since renal malformations are extremely frequent in almost all chromosome abnormalities except for Down's syndrome. Hepatosplenomegaly dictates a search for intrauterine infections.

Genitalia. Sexual ambiguity is a frequent occurrence in both autosomal and multiple X chromosome abnormality. It is also a component of biochemical errors such as the adrenogenital syndrome in the female. The examination should be directed towards detection of true cryptorchidism; hypospadias with or without chordee; clitoromegaly, and so on.

Rectum: Imperforate anus may occur as an isolated finding but, generally, is indi ative of the need to search for other possible gastrointestinal malformations. It may be found with 13 trisomy or in the Schmid-Fraccaro syndrome.

Spine: After balancing the baby in one hand in the prone position, any scoliosis should be noted and followed by x-ray examination to detect hemivertebrae as occurs, for example, in Goldenhar's syndrome.

Neuromuscular: Hypertonicity is a feature of 18 trisomy, while hypotonicity with hyperextensible joints is frequent with 21 trisomy. Varying degrees of neuromuscular abnormality accompany all of the chromosomal and genetic aberrations associated with mental retardation.

Extremities: One of the most valuable examinations (if done with attention to details) is the search for abnormalities in the extremities. Cubitus valgus is common in Turner's syndrome and Noonan's syndrome. Radioulnar synostosis is present in multiple X syndromes and may be detected by the restriction of forearm pronation and supination. Radial hypoplasia or aplasia is a component of Fanconi's anemia syndrome. Sacral and femoral hypoplasia may be found in infants of diabetic mothers. Short digits (especially fourth and fifth) are found in numerous chromosomal and genetic syndromes. Elongated digits indicate the possibility of Marfan's syndrome. Digital posturing such as overriding second over third and fifth over fourth are characteristic of 18 trisomy. Broad thumbs and toes which protrude are found in Rubenstein-Taybi syndrome, while recessed broad thumbs and toes with spatulate digits are a feature of the otopalatodigital syndrome. Syndactylism contributes to a diagnosis of Apert's syndrome, while polydactylism is frequent in 13 trisomy. Absent thumbs are found in Fanconi's anemia syndrome, while thumblike index digits with absent thumbs are found in the Holt-Oram hand-heart syndrome. Lymphedema is expected with Turner's syndrome and Milroy's disease. The nails are hypoplastic in Ellis-Van Creveld syndrome, hyperconvex in Turner's syndrome and other chromosome abnormalities, and deformed on the thumb and index digit in the nail-patella syndrome. Short incurved fifth digits are frequent in 21 trisomy and numerous genetic syndromes. Dermatoglyphic patterns can assist in diagnosis, e.g., increased simple arches in 18 trisomy; increased ulnar loops in 21 trisomy; increased whorls in autosomal partial deletions; transverse palmar creases in numerous chromosome abnormalities, including 21 trisomy; and wide, distal ATD angles in the latter and Turner's syndrome.

As a simple aid to diagnosis, more than one-half of chromosome abnormalities of all types have been noted to include at least one of the following four minor malformation features:

1. Eyes slanted up or down
2. Loose posterior cervical skin

3. Deformed ears

4. Wide, distal ATD angle and transverse palmar crease.

If physical examinations are directed towards defining multiples of the above minor malformation, the physician will have clues as to which patients require more extensive investigations, i.e., chromosome analyses, special x-ray examinations, extensive family pedigrees, serological tests for intrauterine infections, and so on.

Accurate diagnosis is the keystone to genetic counseling. Only with an accurate diagnosis may the family be reassured with regard to future pregnancies if the condition is a sporadic event; or warned with regard to future pregnancies if there is high risk for recurrence.

65 Bergen Street

Naming a New Drug: Mythology, Greek Etymology, and Anagrams Play a Part

By the time the generic name for a new drug takes its place in the pharmacopoeia it will have gone through a number of processes—romantic, as with the titles deriving from Greek mythology; academic, as with names from the ancient Greek etymology; or prosaic, as with those names that are merely anagrams of their molecular pedigrees.

Over the past quarter-century, the therapeutic drugs from Lederle Laboratories have been of the latter two kinds—there have been no romantic designations like the "Mercury" or "Apollo" space flights of aeronautical science.

Two celebrated Lederle Products, Aureomycin® and Achromycin® are examples of the academic (Greek etymology) approach. *Aureo* means "golden" and *achro* means "colorless." Still another, Declomycin® (with the generic name of demeclocycline) is strictly anagrammatic.

With the introduction of its latest broad spectrum antibiotic, Minocin® (minocycline), there is the suggestion that the prefix might derive from Minos, the title of the prehistoric kings of Crete whose symbol, the labyrinth, signified the endlessness of the life cycle—not so. With due respect for Greek mythology, it must be pointed out that the name minocycline (and thus the trade name Minocin) represents an anagrammatic construction based on amino. King Minos and the life cycle, unhappily, have nothing to do with it.

Two rare catalytic agents, palladium and rhodium—each getting their names more or less directly from Greek mythology-etymology—are used in the production of Minocin®. Palladium derives from the title of the Greek goddess Pallas Athena, signifying "protection" or "safeguard." Rhodium has a Greek language derivation meaning "rose-tinted," which relates to the color of dilute rhodium salts. Lederle calls Minocin® its most "exotic" broad spectrum antibiotic in the past twenty years.

Palladium and rhodium are not native to the United States, and where they are mined together—Canada, The Netherlands, the USSR, and South Africa—the quantity is so small in contrast with their importance as chemical catalysts that their cost (rhodium about $250 per Troy ounce) would be prohibitive, if Lederle engineers and chemists had not devised a recycling system that effects conspicuous economies.

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Tomato Rice, Old Fashioned

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Exchange Substitution for 1 Meat and 1½ Bread

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Split Pea with Ham

Exchange Substitution for ¼ Meat and ½ Bread

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Chicken Noodle

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*To obtain copies of "Recommendations for Placing Campbell's Soups Into Exchange Lists," suitable for distribution to patients, write to Campbell Soup Company, Dept. 500, Campbell Place, Camden, N.J. 08101.

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1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. ***21****:674-680 (Sept.-Oct.) 1958.*

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Precautions: Lomotil is classified as a Schedule V substance by Federal Law with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages



should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended average initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo.... ½ tsp.* t.i.d. (3 mg.)
6-12 mo... ½ tsp. q.i.d. (4 mg.)
1-2 yr..... ½ tsp. 5 times daily (5 mg.)
2-5 yr..... 1 tsp. t.i.d. (6 mg.)
5-8 yr..... 1 tsp. q.i.d. (8 mg.)
8-12 yr..... 1 tsp. 5 times daily (10 mg.)
Adults:.....2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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Prevention and Early Detection of Alcoholism

Michael Shenkman, M.D./Westwood*

Like other physicians I have had my share of patients with problems due to alcoholic beverages. I have seen them in all "facets and phases" (Marvin A. Block). I have seen them "dead stoned" at the beginning of week-ends, asked by their respective spouses "to dry them out" and "make them ready" for Monday morning. I have seen them in the hospitals suffering from practically all the known complications attributed to excessive consumption of alcohol over a period of many years. And I have seen them dying from hepatic coma, cardiovascular diseases, fulminating respiratory infections or just dimming out vegetably, so to speak, with diffuse cerebral dysfunction and atrophy. I have noted young adults, in their forties, who died from all kind of diseases but with a primary diagnosis of chronic alcoholism. The dead and the living had come from all walks of life, both sexes, and all trades.

That alchoholism is an insidious, slow-progressing, crippling, and killing disease was never in doubt in my mind—at least for the last eight years. Paraphrasing Jellinek,[3] all those people who "drink themselves to death" whatever the reason may be are "out of their minds" and must be terribly sick. If not, they would certainly not do it—would they?

One afternoon I was struck (not by lightning) by a simple, self-evident, logical idea. If it takes 10, 15, and at times 20 years for alcoholism to be fully developed; if the potential alcoholic does not become alcoholically sick "all of a sudden," why don't we "catch him" and detect his early signs and symptoms due to his drinking, through an educational and preventive program on a countywide level, under the leadership and guidance of doctors? Why don't we do exactly what the American Diabetes Association is doing year after year with their preventive programs?

I prepared an *ad hoc* questionnaire and sent it to Dr. Marvin A. Block. He was all for it. He approved the questionnaire and encouraged me to go ahead. At this time, it gives me so much pleasure to express my gratitude to Dr. Block for the good he did for so many people in our community. I then presented the plan to the Bergen County Medical Society and it was heartily approved. We encountered no difficulties in getting support from the State Department of Health. The National Council on Alcoholism (northern area) was more than happy to go along, especially with our plan to run the project in conjunction with the Alcoholism Information Month. The Bergen Chapter of the American Academy of Family Practice joined our program.

The Record, our county's largest newspaper joined in the effort. Radio WJRZ did the same. Dr. Rufus R. Little, Superintendent of Bergen Pines County Hospital, graciously offered the hospital facilities. We did not have "to draft" our doctors—members of

*Chairman of the Bergen County Medical Society's Committee on Alcoholism.

our committee on alcoholism—they all accepted enthusiastically to serve as medical examiners and interviewers during the program. Several other physicians were welcomed aboard. We prepared an *ad hoc* kit for the doctors to be in charge.

To the community of Bergen, through the distinguished reporters like William A. Caldwell and Roger Burne, we tried to be understandable. We invited people to come to the hospital during any of the three evenings available. They would be asked to answer a questionnaire handed to them by nurses. We reassured them that their answers were private and confidential. They were assured that they could discuss their answers with a physician privately and confidentially. Our goal was not to diagnose, not to treat alcoholism. Our aim was to detect, to pick up early signs and symptoms due to or in connection with an abnormal pattern of drinking alcoholic beverages. If the medical examiner could find none, he would have no objections to their way of drinking as they did, inviting them to come again next year for another preventive checkup, as they would regularly do with other preventive programs offered to the community.

If, on the other hand, signs or problems were picked up by the examiner, advice, suggestions, and recommendations would be given on the spot.

Phase One

One hundred and thirty persons, from all walks of life, both sexes, and all trades participated in Phase I. They filled out their questionnaire, discussed their answers with a physician, and got on-the-spot advice and recommendations when called for. Sixty-nine of 139 were males; the oldest—an attorney of 66; the youngest—a student of 17. Agewise, the main distribution was found between the early forties and early fifties. Nine had been divorced, 106 were married; eleven single; one separated; and three were widowed. Forty per cent left the clinics in a happy manner, for no problems were elicited in their drinking pattern and/or related behavioral outlets.

On the other hand, 60 per cent of the interviewed people showed deviation from an inoffensive pattern of drinking with problems of a minor or greater extent. Three females and eighteen males had serious problems. Fifteen of them gave consent for release of the data to their family physicians or to the Alcoholism Treatment Center at Bergen Pines County Hospital for further help and for rehabilitative treatment.

What personally impressed me most was the disillusionment of many people who had thought that alcohol would solve their problem of loneliness, boredom, anxiety, or tension.

We appreciate the magnificent job done by the branches of the National Council on Alcoholism across the country; by the numerous chapters of Alcoholics Anonymous, state agencies, and institutions which try to disseminate the concept of alcoholism as a disease. But consider how much greater is the effect when the same informative data is received from physicians, especially during a prevention program as this one herein presented.

Phase Two

During the last week of January 1971, we conducted Phase II of our Early Detection and Prevention Program on Alcoholism. Six hospitals participated, and we thank the staffs and administrators for cooperation. Justin L. Faherty, a reporter and medical writer covered our program on the pages of *The Record*. In every hospital, a physician was in charge of the program. In all, 18 doctors participated as examiners: 4 psychiatrists; 8 internists, and 6 general practitioners. We also welcomed the help of 2 psychologists, one counselor on alcoholism, and several registered nurses.

In spite of the bitter cold and windy weather during two of the four days, 150 persons participated in the program. This represented a

Bergen County Medical Society Alcoholism Detection Week
Phase II

General Information Questionnaire

1. Sex _____ Age _____ Occupation _____
   Single, Married, Divorced, Widow(er), Remarried—once or twice
   Address _____ Telephone _____
   Self-employed? _____ On a job?_____ How long? _____
   Do you live alone? _____ With spouse? _____ With children? _____
   How many children? _____ How old? _____
2. What kind of drinks do you use, Check each one.
   Beer _____ Wine _____ Cocktails _____ Sherry _____ Whiskey _____ Brandy _____ Others _____
   Do you mix drinks _____
3. When do you drink?
   Only occasionally as weekends _____ holidays _____
   In the morning (to start the day) _____
   At lunch time during a working day _____
   After work before arriving at home _____
4. How many do you drink?
   Bottles _____ glasses _____ jiggers _____ cocktails _____
5. Where do you drink? _____
6. Do you drink alone _____ With your spouse _____ While at dinner time with family _____
   With friends _____ With co-workers _____ With strangers _____
7. Why do you drink?
   Because you are bored _____ To relax after work _____ To enjoy company _____
   To get relief from physical pain _____ To get relief from a headache _____
   To get rid of stomach pain or distress _____
   To get rid of tension, to get relief from anxiety _____
   To get rid of a hangover _____ In order to sleep better _____
   For self encouragement _____ to obtain social ease. _____
   To relieve feeling of inadequacy _____
8. Have you ever experienced a brief loss of memory after drinking? Yes _____ No _____
9. How important is drinking to you? None _____ Quite _____ Very _____ Explain your answer.
10. What does alcohol do to you? _____
11. Do you enjoy company without drinking? Yes _____ No _____
12. How is your tolerance to alcohol? Increased _____ Decreased _____ No change _____
13. Can you stop drinking when your friends still do? Yes _____ No _____
14. Do you continue drinking when your friends stop? Yes _____ No _____
15. Did you ever say "No" when it seems to you that you need a drink? _____
16. How do you drink? Sipping _____ Gulping _____
17. How do you space your drinks? Every hour _____ Less _____ More _____
18. When on a party, how many drinks do you usually have—1, 2, 3, 4, more?
19. How do you like your drinks: Straight _____ Diluted _____
20. When drinking, do you (1) measure into a glass _____
    (2) Pour direct into glass _____ (3) Drink straight from bottle _____
21. Do you have at least one drink every day? _____ Yes _____ No _____
22. When on a party do you know *exactly* how many drinks you had? _____
23. Do you drink on an empty stomach _____ with a meal _____ after having eaten _____
24. Do you have to have a drink at a special time of the day ? Yes _____ No _____
25. Is there any problem with your job because of your drinking? Yes _____ No _____
26. Is there any problem with the police because of your drinking? Yes _____ No _____
27. Is there any problem with your neighbors because of drinking? Yes _____ No _____
28. Have you ever become involved in an automobile accident because of your drinking? Yes _____ No _____
29. Do you ever "take one for the road"? Yes _____ No _____
30. Is drinking endangering your health? Yes _____ No _____
31. Does your spouse approve of your drinking? Yes _____ No _____
32. If above answer is "no":
    Does it cause problems at home (such as tension, arguments, etc.)? Yes _____ No _____
33. If you argue, are your children present? Yes _____ No _____
34. Were you ever intoxicated because of your drinking? Yes _____ No _____
35. If the above is "yes", how many times during the past 6 months? _____
36. How many years have you been drinking the way you drink now? _____
37. Do you think you may have a problem with drinking? Yes _____ No _____

13 per cent increase over the last year's participation. In Phase II, there were 85 men and 65 women. Fifty-four per cent showed deviation from a healthy pattern of drinking or had problems related to it. Forty per cent of those problem drinkers were advised to get further help and were referred to their family physicians, or to the Alcoholism Treatment Center at Bergen Pines.

Inoffensive drinkers, without problems were on the increase this year (46 per cent compared to 40 per cent last year). This suggests, that the idea of prevention and early detection of alcoholism is starting to take roots in the public minds as a worthwhile community service. Eighty persons said they drink to enjoy company. Sixty-eight told us they drink in order to relax after work.

The real value of our preventive program becomes evident upon examining the other reasons given for drinking. Here they are:

50 to get relief from anxiety
26 to obtain social ease
19 to overcome boredom
7 to decrease tension
6 to get over hangovers
1 "to achieve total escape"

All of the participants, so we hope, had it pointed out to them that these factors would never be resolved with the use of alcohol.

Twenty-eight reported that they gulped their drinks. Not all of the 77 problem drinkers were gulpers—they were drinking slowly, and slowly and gradually they got themselves into their problems with and through the alcohol they consumed.

Other pertinent statistical data related to Phase II will be found in the tabulations.

Table I

Hospital	#	M	F	Mar	Re Mar	Sgl	Div	Sep	W	No Prob	Tot. Prob	Heavy Prob
Bergen Pines	65	34	31	45	4	10	1	1	4	41	24	9
Hackensack	25	13	12	17	2	5	—	—	1	11	14	3
Pascack Valley	25	15	10	21	3	1	—	—	—	12	13	6
Valley	13	8	5	9	—	3	—	—	1	3	10	5
Englewood	7	4	3	5	—	1	1	—	—	2	5	3
Holy Name	15	11	4	14	—	—	—	1	—	4	11	5
Total	150	85	65	111	9	20	2	2	6	73	77	31

Table II

Hospital	10 to 19*	20 to 29	30 to 39**	40 to 49	50 to 59	60 to 69	70 to 82*
Bergen Pines	1	10	17	19	11	6	1
Hackensack	—	6	8	6	5	—	
Pascack Valley	—	2	6	9	7	1	
Valley	2	—	2	—	8	1	
Englewood	—	2	1	2	1	1	
Holy Name	—	2	4	5	3	1	
Total	3	22	38	41	35	10	1

*The youngest was 18 years old; the oldest, 81 years old.
**Disregarding the 3 in the age group under 20 and the eleven above 60, the average age of those tested was 34.

Table III

Hospital	Total Problem Drinkers	M	F	Average Age	On the Job	Severe Problem Drinkers	M	F	Average Age	On the Job
Bergen Pines	24	19	5	39	20	9	7	2	40	8
Hackensack	14	10	4	44	7	3	2	1	44	1
Pascack Valley	13	10	3	41	13	6	6	—	41	6
Englewood	5	2	3	48	2	3	1	2	45	1
Valley	10	5	5	43	7	5	3	2	50	4
Holy Name	11	8	3	41	8	5	3	2	31	4
Total	77	54	23	43	57	31	22	9	42	24

Conclusion

Alcoholism can be prevented and arrested. It can be prevented, to a great extent, through a coordinated, planned program under the leadership of organized medicine. The voice of every physician should be heard when he comes in contact with patients showing early signs or symptoms due to drinking alcohol. Let all medical societies in the USA organize and promote preventive programs like this one. This will have an impact in the secondary prevention of a disease which afflicts, according to the latest data available, nine million Americans.

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Physicians have, perhaps, not been fully aware of their responsibilities both in the recognition and follow-up of battered children.

Management and Follow-up of Child Abuse

John G. Cosgrove, ACSW/Newark*

In July of 1970, for several reasons, we at Martland began to look more closely at the problem of child abuse as it presented itself at our hospital. There was concern on the part of the staffs of the Pediatric and Social Service Departments about these children and what happened to them before, during, and after the time that they were known to us.

It was hoped that this would enable us to evaluate the efficacy of our management of these situations. Furthermore, we wanted to give some feedback to the house staff and medical students concerning what happened to abused children after they left us. The positive involvement and interest of the staff and students might thus be engaged in an area which should be an essential part of their training. This was particularly important because there seemed to be some skepticism, or at least uncertainty, as to whether what was being done with and for the children was effective or constructive.

Coinciding with the study was the beginning of a particular, if limited, effort on the part of the author with suspected child abuse cases at Martland. I acquainted myself with the law governing reporting of these incidents by hospitals and physicians.[1] I also got to know the personnel and procedures of the agencies directly and indirectly designated by that law to act on the reports.[2] Thus I was available to consult with the staff on these matters. In addition, all reports to the prosecutor were channeled through me and I coordinated the contribution of the hospital on behalf of the child and family with that of the other agencies. This involved anything from relaying a message from the Bureau of Children's Services to the family, to helping to construct an individualized treatment plan with the family and other agencies.

While the parents were told that the hospital had a legal obligation to report, it was explained that we were primarily motivated by concern for their child and them. Our approach was neither one of condemnation nor a condoning of what might have happened. An attempt was made to create an atmosphere of acceptance of the parents as people and to convey a willingness and capacity to help.

It can be, of course, difficult to achieve these goals in the face of severe injury or the hostile or unconcerned demeanor of the parents. At such times it helped to keep in mind that there was usually a tragic and painful parental history which found expression in the abuse. Remembering this can also help to attune one to those clues of past difficulties which hold the key to the resolution of the present problem. These parents often have had great difficulty in forming any kind of trusting relationship with anyone.

* Mr. Cosgrove is Pediatric Social Worker at the Martland Hospital Unit (CMDNJ) in Newark.

[1]Ch. 30, 9:6-8, Revised Statutes
[2]Prosecutor, local police, and the New Jersey Bureau of Children's Services (BCS)

A very practical reason for a careful receptive approach would be to ensure the cooperation of the parents in, at least, the immediate protection and treatment of the child. At present, a hospital does not have the authority to hold a child against the will of the parents until the question of possible abuse has been cleared. The alternative mechanisms for protection of the child can be traumatic to all concerned, as well as too slow.

I attempted to remain involved with the families beyond the reporting stage. During the initial trying period of the investigation parents often can see only what appears to be an accusatory or punitive procedure. Whether this perception is correct or not, it only confirms in them a method of dealing with problems with which they are already only too familiar.

Clearing up misunderstandings between the parents and investigating agencies or clarifying the role of the latter can be quite helpful in diminishing the likelihood that the family will be unreceptive to rehabilitative efforts.

Long term follow-up was secured on virtually all of our cases when children remained in their homes. Most often this was automatic when abuse was verified. However, at other times it was attained by encouraging acceptance by the parents of the services of the BCS†; a combination of agencies whose coordinated services would best meet the needs of the family; or failing these, the acceptance of any involvement by any responsible party who could monitor the welfare of the child.

Continuous help to the family is essential, especially in situations where the outcome must be in opposition to the parents' wishes, e.g. removal of the child. Anything less is shortsighted for that is where the problem began and where it could once again appear. It is not humane to abandon troubled and unhappy people who have just sustained yet another insult to their integrity. In these situations, ongoing counseling was offered from our staff or use of other resources was encouraged.

Having described the origin of our interest in, and our management of, child abuse there will follow an analysis of the cases we saw during a one year period—what these children were like, why they came to us, and what has happened to them since they were reported.

The study covered the period from mid July 1970 to mid July 1971. Three quarters of the cases are more than seven months beyond the reporting stage. While a review over a longer period of time will be of greater interest and importance, nine months is a significant time.

Number and Distribution of Cases

The total number of children who are identified as "possibly abused" is always too high since even one is unacceptable. Unfortunately, we must expect that we will continue to see them. In our survey fifteen children were reported to the prosecutor during this period as being "possible victims of abuse." One can be certain that there were more. For many reasons, several of which we cannot control, some cases will not be identified. It is certain that those which were identified were, by clinical evidence and/or patient or parent behavior, fairly clear. No cases were reported in July and October of 1970 and January of 1971. However, there was no definite seasonal pattern.

Family Structure and Characteristics

There will be no attempt to describe the structure and characteristics of the families involved. In general, they were representative of the community we serve in terms of race, social and economic status, education, composition, and so on. There is simply no easy way of identifying potentially abusive families.

† Bureau of Children's Services

With little, if any, exception the literature would lead us to expect that we would have had more male than female victims. Our patients conformed to this pattern, nine of them being male, six female. It is usually held that boys are more difficult to handle than girls during the early years. Since battered children are most often vulnerable infants, toddlers and pre-schoolers, this accounts for the over-representation of boys. Abused children are usually found to be quite young. This proved to be true with our children: 0 to 6 months—4; 6 to 18 months—3; 18 months to 3 years—3; 3 to 6 years—1; and 6 and over—4 (oldest 9 years and two months).

Two thirds were under three years of age. The average age was three years seven months and the median age twenty-one months. The victims are most frequently small, defenseless, and spend most of their time within the confines of the home.

Injuries

To make for a comprehensible overview of the injuries sustained the following categories were established:

Head Trauma—This includes what are certainly serious, if not the most serious, injuries—skull fractures and subdural hematomas. Three children sustained fractures, one multiple and one including subdural hematoma.

Other Fractures—This category involves all fractures in areas other than the skull. Six children suffered these injuries. In four of the instances the fractures were multiple.

Burns—Two children were burned, one seriously and one secondary to more substantial soft tissue trauma.

Malnutrition—One child was severely malnourished. Growth hormone deficiency had first been suspected but subsequent growth in a foster home has been spectacular.

Soft Tissue Trauma—All of the children, save two, sustained soft tissue trauma. This covers bruises, scratches, welts, lacerations, and the like. They ranged from minor and isolated wounds to extensive and varied injuries. Five children had no other evidence of abuse than soft tissue trauma. The pervasiveness of this injury, then, would seem to be of important diagnostic significance.

During the period of this study "only" one of the fifteen children was known to have been abused again. This is encouraging since child abuse has been looked on as a chronic problem with repetition the rule rather than the exception.[3]

The present situation of most of the children we did report is very much brighter since then. One child who was initially placed in foster care has since been returned to his home. Eight others are still with their families. It was not possible thoroughly to assess the quality of care in these homes but there seems to have been some improvement in most, in a few quite obviously. In one instance abuse has reoccurred, in one or two others there has been little discernible improvement. In these cases the supervision and, if possible, the treatment continues.

In addition to the one child since returned, five more children had to be removed from what was considered an inadequate or dangerous situation. They are all still in foster care and three are reported to be doing especially well. Foster care rather than placement with relatives had to be utilized in five of the six cases, which says something for social isolation as a possible factor in child abuse.

Conclusions

1. What has been described here is a brief overview of the management and follow-up of child abuse cases in our hospital over the period of a year, including the specific input

[3]Unfortunately, a second child from the original group has since returned to the hospital with what is either a repetition or complications from the original injury.

employed and the philosophy that undergirded it. Abuse is considered symptomatic of chronic pathology in the home environment of the child. Abuse aroused strong emotional reactions that could be destructive. Both factors had to be considered in the initial approach and continuing work with each case.

2. Immediate treatment and protection of the child were looked on as only the first step in proper management. Long term follow-up was considered essential to the well being of the child and for rehabilitation of the family.

3. Understanding of, and cooperation with, the investigating and other community agencies was important throughout these efforts.

4. There was little about the children who came to us that would make for easy or early identification. However, there are two areas not usually given much diagnostic significance that perhaps deserve closer attention by physicians and others working with children—insufficiently explained soft tissue trauma and the social isolation of the family: i.e., the absence of relatives or other persons willing and able to provide support or substitute parenting.

5. It would be interesting to compare similar analyses in other hospitals and communities. If this presentation serves to create enough interest to accomplish this it will have been worthwhile.

6. It is also hoped that some optimism will be generated, for it would appear that the cooperative efforts of the hospital and community agencies have had some degree of effectiveness despite limitations of time and resources. This is even more encouraging when viewed in terms of the potential for even greater effectiveness.

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The Conservative Approach to Ovarian Enlargements*

William J. Sweeney III, M.D./New York

The conservative approach to ovarian enlargements is here presented through two avenues: (1) The prospective management of the patient who was examined and found to have ovarian enlargements or (2) the prospective therapy of the operative patient in whom the histologic reasons for the ovarian enlargement were known. It is a different matter to lecture on the approach to a histologically proved dermoid cyst of the ovary than it is to discuss the management of a twelve-year old child in whom a large pelvic tumor is found.

Conservative by definition is: (a) tending to favor the preservation of the existing order, (b) moderate, prudent, cautious, and (c) traditional in manner or style. However, we have all known situations where a more extensive operative procedure may be the more conservative approach. For example, total abdominal hysterectomy and bilateral salpingo-oophorectomy may be a radical operation in a young women with acute pelvic inflammatory disease with a ruptured abscess; it may be a conservative approach to her life. Therefore, we do not necessarily equate conservatism with less than adequate therapy.

Ovarian Enlargement in Childhood and Adolescence

Almost all textbooks apply the five centimeter rule when discussing ovarian enlargement in this age group, but it has been our experience (especially in the children or early teenage girls) that rarely do we have the opportunity of finding and following an ovary less then five centimeters in size. Most children with ovarian enlargements are not seen until the tumor is much larger and indeed has become an abdominal organ.

Now that we are seeing more young and late adolescents then ever before (because of requests for birth control pills) we have the opportunity to observe earlier ovarian tumors, cysts, thickenings, or neoplasms in this age group. We are also seeing more adnexal pathology due to inflammatory processes.

What should be our conservative approach to the sixteen-year old girl who presents herself for birth control pills and in whom we find a five centimeter cystic right ovary? I suggest that we would reexamine this patient the following month at a different time in her cycle and if there were no change, follow her at prescribed intervals. What should be done for the fifteen-year old with amenorrhea or oligomenorrhea in whom bilaterally enlarged ovaries are felt? Is it conservative merely to reassure the young lady and her mother that all will be well, or should the child be subjected to a minute search for the endocrinologic or functioning ovarian tumor causing her amenorrhea? I would cast my vote on the traditional conservative side here and in the absence of other signs and symptoms (Turner's, drug addiction, hirsutism, enlarged clitoris, and so on) would suggest close supervision of diet (especially in the obese or slightly

*Read before the Section on Obstetrics and Gynecology, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 16, 1971. Dr. Sweeney is Professor of Obstetrics and Gynecology at the Cornell University Medical College, and Attending Obstetrician and Gynecologist at the New York Hospital.

chubby child), a minimal thyroid evaluation, and a course of progesterone. If menses follows, I would repeat this therapy for several months and then withhold this drug and observe her. In many cases, normal regular periods follow. If amenorrhea returns, one would be justified either in a continuation of the progestational agent or the search for the cause of the abnormal cycles and ovarian enlargement. I see little justification in an immediate expensive "full-work-up" in all of these young women. Wilkins[1] reported that in 3000 patients referred for an endocrine study, only 846 had true endocrine problems. Neither do I see the need for bilateral wedge-resections or clomiphene citrate in these young patients. Southam[2] states that such drugs in adolescents are justified only when more frequent ovulation might increase fertility. I wager that there are not many fifteen-sixteen-year olds brought in by their mothers who desire to increase their fertility.

However, what of the twelve-year old who is seen because of an enlarging abdomen with the finding of a large intra-abdominal mass? Here the conservative approach is no longer a "moderate, prudent, and cautious" one. In this case, a complete "full work-up" should be instituted at once with all the diagnostic modalities employed and fully evaluated. In any event, surgical exploration is mandatory! What is our conservative responsibility to the parents in this case? They should be fully informed of the possibility of a malignancy and the gynecologic surgeon should have full authority to remove those structures necessary at the time of operation. Anything less than this is not conservative, but radical. Once the abdomen is opened the decision becomes even more difficult to make. Even the most radical surgeon is aware of his desires, the desires of this twelve-year old girl, and the desires of her parents to maintain her normal reproductive potential. Yet, in certain tumors, extirpation of both ovaries and uterus is the proper approach. In some instances, such as dermoid cysts, the surgeon's decision is easier. Enucleation of these tumors with preservation of ovarian tissue is the correct and conservative approach. The contralateral ovary should always be bisected and inspected for early foci of neoplasm and removal of them. What about the dysgerminoma? Here is a tumor with acknowledged malignant potential. Yet there is vehement disagreement as to the proper conservative approach. Whelton[3] sums it up best when he states, "At the time of surgery, the gross specimen should be immediately examined by the pathologist and a frozen section performed on a representative part of the tumor and from any other sections which have different gross characteristics. The demonstration of any coexisting malignancy arising from germ cell origin requires radical treatment in every instance. With this exception: if no gross evidence of dissemination is observed, the opposite ovary is bisected to the hilar region and a slice biopsy of the ovarian substance taken, using clean instruments and a change of gloves. With the aid of a cryostat, an immediate microscopic report on this tissue can be obtained. Gross or microscopic involvement of the contralateral ovary requires bilateral salpingo-oophorectomy and hysterectomy. The same therapy is indicated in older women or in any patient who has already had her family, even though the opposite ovary is thought to be uninvolved. Normal gross findings on bisection of an ovary supported by negative microscopic examination of an ovarian biopsy favor the reasonable conclusion that no metastasis is present, and in young patients the ovary should not be excised."

Ovarian Enlargement in the Childbearing Age

In this age group (18 to 40) we find ourselves with the luxury of periodic examinations. Here we have the opportunity to follow the small ovarian enlargements and apply the time-honored (but perhaps erroneous) five centimeter rule.

Even here there is a change in our conservative attitude as the patient approaches forty. In primary ovarian surgery in the young woman the place for a conservative approach is both at the preoperative examination and at the operating table. The conservative approach for the older woman is more at the

preoperative examination and less at the table. Our problem in the older age group is not only the conservative approach to the ovarian enlargements, but the conservative approach to the normal ovaries. We all agree that an ovarian cyst or solid enlargement 6 to 7 centimeters in diameter in a forty-year old patient requires exploration. But do we agree that the normal ovaries should be permitted to remain in a woman of forty undergoing a hysterectomy for myomas? Each of us must have an age where we allow normal ovaries to remain and above which we prophylactically remove them. No one will be correct 100 per cent of the time, and there will always be the one case to haunt us forever—the woman of fifty-five who develops carcinoma in the ovaries we left behind at age forty. While not adamant about the age one chooses to remove ovaries, I am strongly against the concept of removing one normal ovary and leaving the other normal ovary behind. Either we have an indication to remove both ovaries or we have an indication to leave both ovaries.

There is one type of ovarian enlargement seen in this group which should certainly be treated in a conservative manner. This is the patient who develops bilateral ovarian cysts while being treated with clomiphene citrate. It is imperative that a careful history be taken concerning all medications and treatments that a patient might be taking. I recently saw a patient who had huge bilateral ovarian cysts. I was on the verge of admitting her to the hospital, when I asked if she had had any recent therapy or treatments. She replied that she had been to see another gynecologist four months before and he had placed her on pills (the type of which were unknown to her) which she was to take for five days, beginning on the fifth day of her menstrual cycle. She had been doing this for four months and had never been examined by the physician. He was prescribing this drug over the phone on a monthly basis. A phone call confirmed the suspicion that she had been taking clomiphene citrate and did not require any surgical intervention.

In this age group we should use the laparoscope as an aid to our diagnosis and, therefore, our therapy. It is gratifying to see what the ovarian enlargement looks like before deciding the course of therapy. I do not agree that the pelvic examination, even under anesthesia, is as accurate as an actual visualization of the pathology.

A debate has been raging for many years concerning the problem of conservatism in the patient in the child-bearing years who has a unilateral ovarian carcinoma. Munnell[4] has reported on 190 patients with this condition. One hundred and forty-four of these were treated with a bilateral salpingo-oophorectomy and hysterectomy and forty-six treated conservatively. The five year survival in the former group was 70 per cent, and 61 per cent in the latter. However, in thirty-one of the cases of the mucinous type of ovarian carcinoma, twenty-three were treated with complete adnexal removal with a five year survival of 78 per cent; and eight were treated with a unilateral oophorectomy with a five year survival of 100 per cent. On the basis of these figures, the author suggests that if the ovarian tumor is a low grade mucinous cystadencarcinoma and the patient is in the child bearing age, the woman can probably be safely treated by conservative unilateral oophorectomy. However, in the closing paragraph of his discussion, Munnell[4] states, "It is indeed difficult to find a patient who is stalwart enough and has a family who is equally secure to enable her to live with the knowledge that she has been conservatively operated upon for cancer of the ovary. Even the possibility of future childbearing makes it very difficult for most women to be psychologically content with anything short of maximum operation." I find that I must doff my conservative hat here and vote for a radical operation which I feel is the conservative approach to this problem.

Ovarian Enlargement in Pre-Postmenopausal Patients

In the age group over forty, there is little reason for conservative approach to most ovarian enlargements. In this age group, the five centimeter rule should be discarded. Any

ovarian enlargement, cystic or solid, should be immediately and thoroughly investigated. Here there is no place for procrastination and re-examination at another time. While ovarian carcinoma may be found at any age, it is certainly more prevalent in this age group and it is to this problem that we must devote our efforts. Any new adnexal enlargement should be considered malignant until ruled otherwise. Of course, I am not including a patient whom we have been following for years with old pelvic inflammatory disease, but even in this individual, any *further* enlargement of either adnexae calls for immediate action.

All patients should have at least a certain minimum amount of preoperative work-up which should include a chest plate, a thorough breast examination and mammogram if necessary, a gastrointestinal series, and a barium enema. Any laparotomy with the possibility of a malignancy in mind should be preceded by bowel preparation.

If it is apparent we are dealing with a malignant process there is little problem as far as conservatism is concerned. If it appears, however, that the ovarian enlargement is a benign process, a frozen section of the involved ovary should be performed. If it is returned benign we then have the dilemma of the proper course of action. Once again our obstetrical heritage of masterful inactivity raises its conservative head and the albatross of the tissue committee and the accreditation board looks over our shoulder. Randall[5] has already reported on 310 cases where unilateral oophorectomy was carried out in cases of benign ovarian pathology and found development of a neoplasm in the preserved ovary in twenty-one or 7 per cent of the cases. Even in his plea for ovarian conservation Randall exclaims, "perhaps these women tend to develop ovarian neoplasms as long as we preserve their ovarian tissue!" He also notes that of the seven women who developed a malignant tumor in the carefully preserved ovary, every one of the seven died of this malignancy. These figures speak for themselves and the conservative approach in the older age group to ovarian enlargements, benign or malignant, is surgical removal.

As was the case in the child-bearing group the question must be considered concerning the conservative approach to the normal ovaries. What about the ovaries in the patient being explored for benign uterine pathology or the vaginal hysterectomy for benign disease? If the philosophy of bilateral oophorectomy with a unilateral benign neoplasm is acceptable in this age group then the same philosophy should exist for the bilateral normal ovaries in the patient in whom a pelvic operation is indicated for other reasons.

Is there ever an indication for conservatism with malignancy in this age group? Not in the usual sense of the word, but there is always the conservative plea to remember that we are not dealing with a *case* of cancer of the ovary, but a *person* with cancer of the ovary. There is no place for heroic ultra-radical surgery in older patients unless (1) cure of the disease process is strongly contemplated and (2) the cure is not worse than the disease. Many things in this life are worse than death, and I am a firm believer[7] in permitting a person not only to spend her last remaining time in dignity, but also in giving her the opportunity to die in dignity without a tube in every orifice and various bags hanging in different sites. There are those who differ with this opinion. Brunschwig[8] for example, presented the data on 65 patients in whom palliative ultra-radical surgery was performed. His figures show that 34 or 52 per cent of these patients were dead in six months, and 49 or 75 per cent were dead within one year. This article included such statements as found on one page, "In all cases cancerous tissue was left behind, since the wide extent of the disease precluded complete excision." However, on the next page he states, "In all these patients, the histories and clinical findings suggested carcinomatosis, but because laparotomy was performed, disease was found localized and eventually totally resectable". I would submit that this represents fuzzy thinking. Eight years later from the same institution, Lewis[9] reported on 67 patients admitted to

the hospital with recurrent or persistent ovarian cancer. Ten per cent of these patients were admitted with an enlarging tumor mass and fluid accumulation, and in only one was major extirpative surgery attempted. So it seems that even here we are seeing a swing towards a more conservative approaach.

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Automated Health Testing

Because few Americans now die young of infectious diseases, physicians are faced with even greater challenges: chronic diseases such as cancer, heart disease, and diabetes. For these diseases, prevention is the best treatment. The second best is early detection.

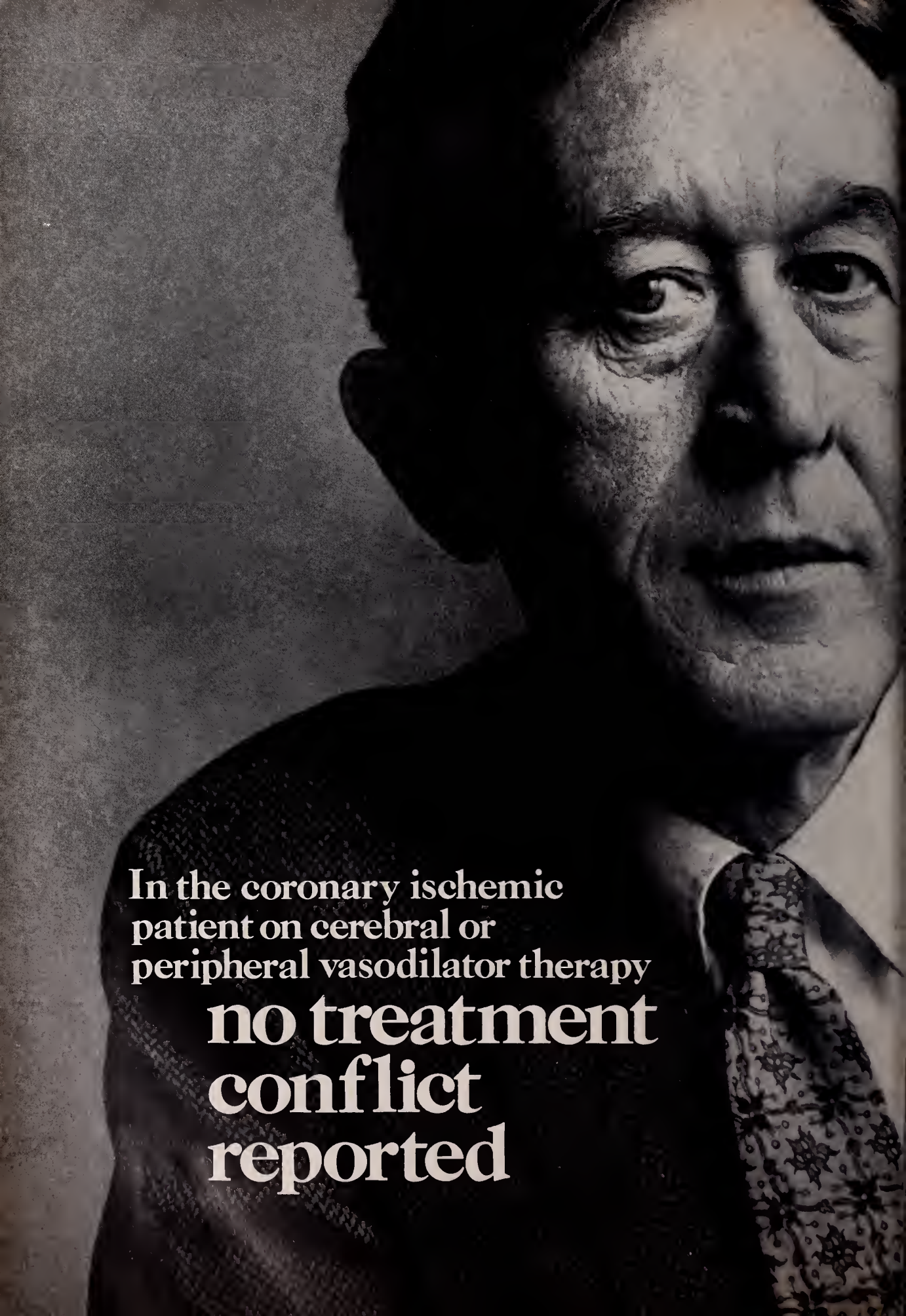
Early Disease Detection—A New Way to Health, by Edward Edelson, discusses methods of finding and treating chronic illnesses before they become serious hazards. This new Public Affairs Pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

One common technic of early detection is screening for a particular disease—the chest x-ray to detect tuberculosis, the Pap smear test for cervical cancer, blood tests to detect the high blood sugar levels typical of diabetes.

A logical development from this kind of screening is multiphasic screening; that is, testing for several diseases in one session. The goal of multiphasic screening is finding abnormalities. A new concept is automated multiphasic health testing (AMHT), which uses technicians, nurses, and computers as well as other automated equipment. "Instead of a concern with detecting specific diseases, AMHT is concerned with maintaining a person's over-all health," stresses Mr. Edelson. "In screening, the major emphasis is on obviously abnormal test results that may indicate disease, or the suspicion that it may occur in the future. In AMHT, the normal results are just as important, since they give a baseline against which the person's health status can continue to be measured."

"Is AMHT worth the cost?" Edelson asks. Some doctors feel there is no clear-cut scientific evidence that people who participate in annual physicial examinations live longer or in better health, or that in the long run early diagnosis will reduce medical costs. So, large numbers of people will have to be checked for years to prove the usefulness of AMHT." Also, a prime point in its favor is that AMHT releases the doctor from many of the time-consuming tasks of checkups which technicians and instruments can perform. In 1970, there were 100 AMHT centers screening about 170,000 people. The Stanford Research Institute estimates that there will be 1,100 centers screening 17.1 million people by 1980.

"Whether as a participant or an adviser," Edelson concludes, "it's wise to get involved in efforts to keep people (including yourself) healthy. The effort should start early. All through life, paying attention to preventive medicine can help make the years ahead healthier and more trouble-free."


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- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: (1) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (4) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May. 1959.

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Hammered out of the experience of more than 300 successful cholecystectomies is a practical monograph of operative technic.

A Method of Cholecystectomy and Operative Cholangiography*

James J. Chandler, M.D., William P. Burks, M.D., and David B. Miller, M.D./Princeton

Cholecystectomy is one of the more commonly performed operations by our three-surgeon team. Our method (which has evolved through combining several effective technical steps) has been utilized in over 300 operations over the past five years. No originality is claimed, but the method is now recommended to others as being efficient, safe, and attendant with low morbidity.

The supine patient receives general anesthesia with endotracheal muscle relaxation. The skin of the abdomen and lower chest is prepared with ether, 1 per cent iodine tincture, alcohol, and is again wiped off with ether to dry the skin prior to placement of the adherent plastic drape. A slightly lateral subcostal incision is made. (Figure 1). The lateral half to one third of the anterior rectus sheath is incised along with external oblique. Hemostasis is achieved through the use of fine silk ligatures. The rectus muscle is usually not cut but is retracted medially (Figure 2). The internal oblique muscle is spread, and the transversalis fascia and the transversis abdominis muscle are divided along with the posterior rectus sheath. The peritoneum is then opened after being tented up. Subcutaneous fat is kept moist. Careful exploration is carried out after opening the peritoneum.

The gallbladder is carefully palpated. Its fun-

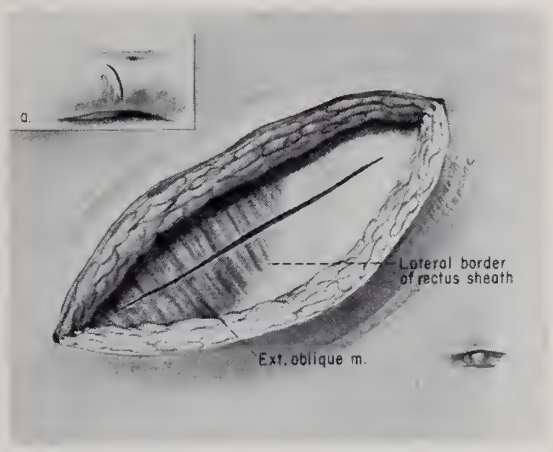


Figure 1. The insert (a) shows a small folded towel under the right inferior thorax. The incision is a lateral subcostal one with division of the lateral one-third of the anterior rectus sheath.

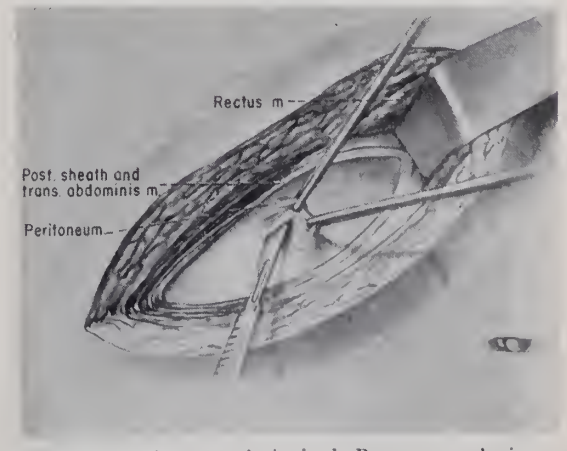


Figure 2. Peritoneum is incised. Rectus muscle is retracted medially.

*Read before the Section on Surgery, 204th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 18, 1970. This work is from Princeton Surgical Associates and the Department of Surgery, Princeton Hospital, Princeton, New Jersey.

dus is grasped with a ring-type gallbladder forceps which includes a gallstone in its blades (Figure 3). Adhesions between the gallbladder and the duodenum or the colon are then sharply divided. A laparotomy pad is placed over the duodenum with the long-handled tissue forceps, and the duodenum is retracted inferiorly with a broad-bladed malleable retractor (not with the first assistant's left hand). A more narrow malleable retractor or a Deaver retractor is then used to lift the liver's quadrate lobe, the retractor being padded with a moistened unfolded sponge. A second gallbladder forceps is used to retract the ampulla (Figure 4). The peritoneal reflexion over the ampulla and cystic duct is then opened with scissors, and lifted off the cystic duct and common duct with blunt and sharp dissection. A useful maneuver when isolating the cystic duct by in-continuity ties has been for the operator to hold the broad malleable retractor while the first assistant ties the cystic duct. Figure 5 demonstrates the method of in-continuity ligature technic used for both the cystic duct and for the cystic artery. The structures are first absolutely identified. Then, the right-angle gallduct forceps is passed underneath the cystic duct while the assistant passes the 24 inch-long 2-0 silk strand to the operator as shown. The cystic duct is tied within 5 millimeters of its junction with the common duct.

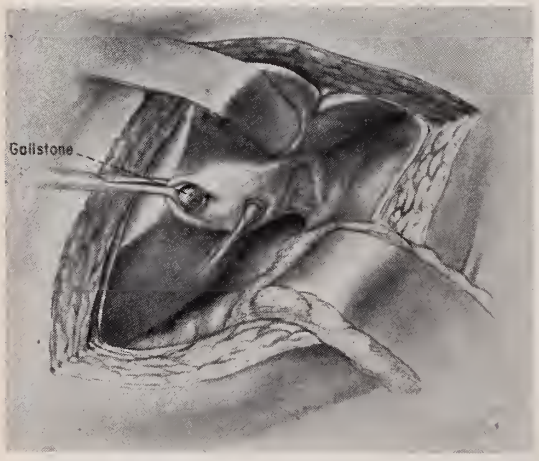


Figure 3. Ring-type gallbladder forceps retract the gallbladder. Duodenal retraction is done with a malleable retractor, which occupies less room in the wound than an assistant's hand. The retractor holding the liver is also padded (pad removed for illustrative clarity).



Figure 4. Left: Peritoneum over the cystic duct has been incised and is being pushed off the duct. *Right:* The operator may turn the right angle clamp to the right and hold the retractor while the first assistant ties the cystic duct.

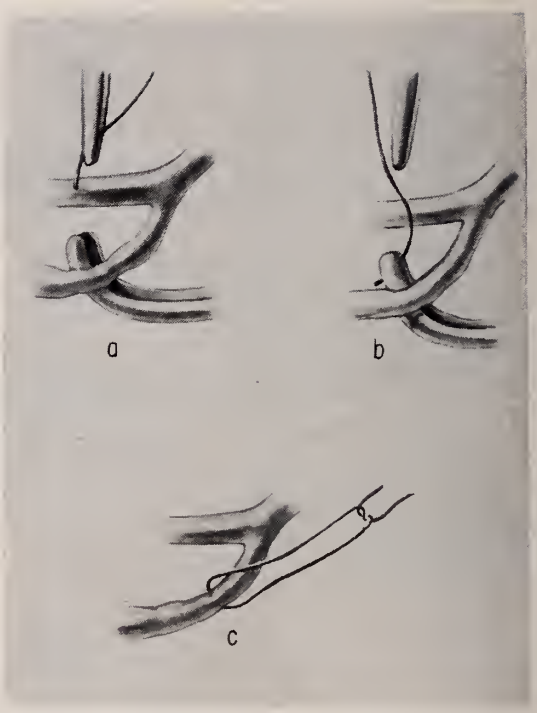


Figure 5. In-continuity typing of cystic duct or artery. The assistant passes 24-inch silk ligature with long-handled smooth forceps.



Figure 6. Both cystic duct and artery are divided after positive identification.

The cystic duct is next clamped toward the gallbladder (Figure 6) and the duct is divided. A similar method is used for the cystic artery, which is also absolutely identified and tied in-continuity twice with 2-0 silk ligatures. The cystic artery is divided right on the gallbladder wall taking care to identify the right hepatic artery when that structure is near the gallbladder. The peritoneal reflexions on either side of the gallbladder's ampulla are cut sharply (Figure 7), and the gallbladder is dissected out of its capsular bed from below upwards while the peritoneal edges are sutured behind the gallbladder with running stitches of 2-0 chromic catgut. Where necessary, individual suture ligatures are used for significant arterial bleeders. A Penrose tubing rubber drain or, in some cases, a cigarette drain is placed with its end near the foramen of Winslow in Morrison's pouch on top of the peritoneal reflexion over the kidney (Figure 8). The drain is then drawn through a stab wound inferior to the operative wound. A pin passed through the drain keeps it from retracting.

The peritoneum and posterior rectus sheath are closed with running stitches (Figure 9), using a doubled strand of 0 chromic catgut. Fascial layers are then closed anatomically with interrupted sutures, figure-of-eight, of 2-0 silk (Figure 10). A few stitches of fine silk then close the subcutaneous layer, and the skin is closed with a continuous subcuticular stitch of 2.0 plain catgut. A moderately bulky dressing is then utilized, which affords some compression against the abdominal wound.



Figure 7. Peritoneal reflections on both sides of the gallbladder are incised, and the gallbladder dissected upward. Peritoneal edges are closed with continuous catgut stitches.

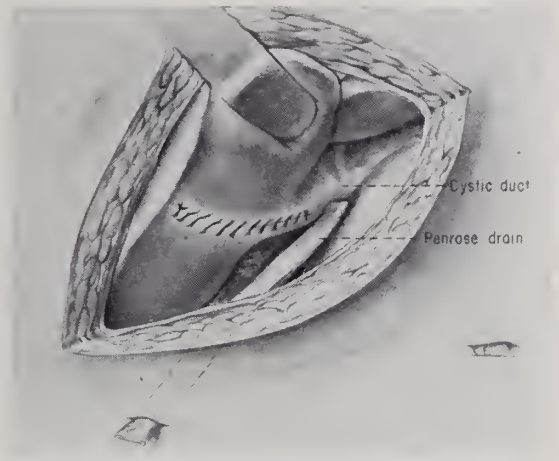


Figure 8. Rubber tubing drain is being placed in Morrison's pouch; lower end of the drain will lie posterior to the common duct and near, not through, the foramen of Winslow.



Figure 9. Rectus muscle again retracted while posterior sheath and peritoneum are being closed.

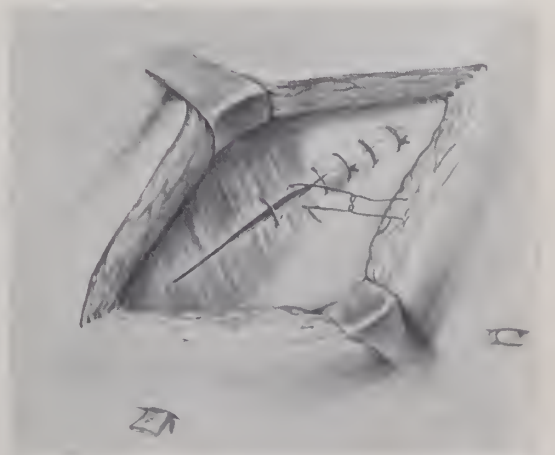


Figure 10. Abdominal Closure. Internal oblique fascia is closed as a layer separate from external oblique.

Operating time has usually been less than 40 minutes. The drain is loosened on the first postoperative day and advancement of it begins on the fourth day. The patient is usually home on the sixth to seventh postoperative day.

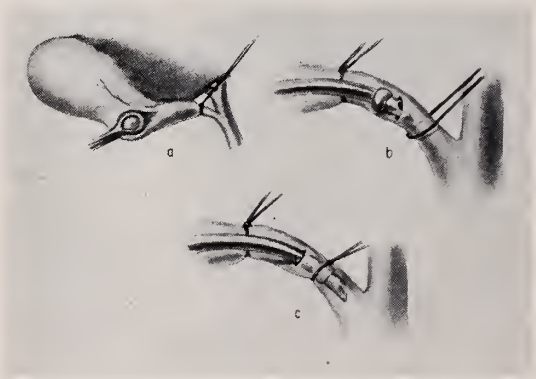


Figure 11. Cystic duct cholangiography. While traction is exerted on the gallbladder, the plastic catheter is inserted into an opening in the duct and the ligature tightened.

We have done virtually all cholecystectomies in the operating room with overhead x-ray equipment. Cystic duct cholangiogram is a routine procedure and is now done in most cholecystectomies. The clear plastic cholangiogram catheter (Figure 11) has proved quite useful in cystic duct cholangiography. Upon identification of the cystic duct and determination that cholangiography is to be done, the x-ray technicians are called to the operating room. The cystic duct is then isolated, and a 2-0 silk ligature is used to tie the duct at its junction with the gallbladder ampulla. A second strand of 2-0 silk is passed around the cystic duct and the duct is opened with a knife or scissors. The tip of the cholangiogram catheter has usually been tailored with an oblique cut of the Mayo scissors, and the catheter is filled with saline solution before passing it into the cystic duct and tying it in place. After removing steel instruments and retractors from the field, two roentgenographic exposures are next taken. The first exposure is taken after installation of 6 cubic centimeters of Hypaque solution through the cystic duct. As soon as the film cassettes have been changed, the second exposure is taken after installation of an additional 15 cubic centimeters of Hypaque solution slowly into the cystic duct.

While the films are being developed, the cystic duct is divided behind the cholangiogram catheter, and the cholecystectomy is accomplished. We receive a report from the radiologist on the intercom while the technician is bringing the developed films back to the operating room for our study. The ductal system being satisfactory, the silk ligature is cut, and the catheter removed while grasping the cystic duct with a right angle clamp. The duct is then tied within 5 millimeters of the common duct and the operation completed.

One death has occurred after cholecystectomy during the past five years. This tragic "arrest" occurred while moving the patient from the operating table to the stretcher. It was undoubtedly due to hypoxia. Despite the use of a running subcuticular catgut skin closure, there has been no increase in wound infection rate. In one patient, who was Addisonian and who had common duct exploration, infection occurred in the drain wound, but not in the operative wound, from the same organisms found in the bile. Wound infections occurred in two other patients who had infected bile and common duct exploration and in two patients with clean wounds. In this series, made up of our last 315 consecutive cholecystectomies, there were no other wound infections.

The use of cystic duct cholangiograms has added no more than ten to fifteen minutes to the operating time for cholecystectomy. This additional time has been amply justified by the valuable information obtained through this technic. Hypaque solution used has varied in concentration from 10 to 50 per cent, most commonly, 25 per cent. We no longer use the 50 per cent solution.

Although we advocate a slightly lateral subcostal incision (with medial retraction of the right rectus muscle), we have no hesitation in dividing the rectus muscle when the needs of adequate exposure dictate this. In this series

there were 304 subcostal incisions and eleven vertical incisions (both "rectus-splitting" and rectus retracting, depending on the training and preference of the operator). Again, although we believe the dissection of the gallbladder can ususally be done safely and quickly from below upwards, in this series there were nine patients in whom the gallbladder was dissected from the fundus towards the cystic duct because of difficulty in identification of anatomic landmarks in the face of acute inflammation. (An additional eight patients had cholecystostomy only.)

Twenty-three of the patients in the cholecystectomy series had common duct exploration. Another five patients who might have had open exploration of the common duct for "minor" indications (small stones and a duct at the upper limits of normal diameter or a very brief episode of elevated serum bilirubin at the time of acute cholecystitis) did not have their common ducts opened after cystic duct cholangiograms revealed normal and unobstructed ductal systems. One patient with open duct exploration is known to have had a "missed" common duct stone; reoperation has not been necessary up to four years later. We know of no other patient with "missed" common duct stone.

Summary

The cholecystectomy technic here described has proved efficient and safe in over 300 operations. A slightly lateral subcostal incision with retraction of the rectus muscle medially, the use of a malleable retractor rather than the assistant's hand, the use of ring-type gallbladder forceps, tying the duct and the artery in-continuity, and the use of operative cystic duct cholangiograms are steps which we recommend.

We acknowledge the contributions to this technic made by Ralph J. Belford, M.D., Princeton surgeon since 1929.

Medical Arts Building

Slow Blinding by Ischemia

A slow torturous case of natural blinding, which led its victim to suicide, is detailed in the October 1971 issue of *Transactions,* published by the American Academy of Ophthalmology and Otolaryngology.

The tale is described by Drs. David L. Knox and James R. Duke of The Johns Hopkins University and Hospital, Baltimore. A 55-year old man had been losing vision in the nose side of his left eye. He had had trouble with his eyesight since he was five years old. When he was 40, a cataract was surgically removed from his right eye, which then had a normal field of vision. Because of the slow deterioration of vision in the left eye, the doctors thought he had suffered a retinal detachment. The vitreous was foggy, so they cut out a segment of his iris. They found no detachment of the retina. However, "the patient considered his ocular disease as punishment for past moral transgressions and he committed suicide by jumping from a third floor window."

Autopsy showed that the arteries of his body were clogged with fatty deposits. The left common carotid artery that should have fed red blood to his head was completely plugged. It was this ischemia which caused his blindness. Lacking blood, the left optic nerve deteriorated. It also caused swelling of the optic nerve head. This case is particularly significant, because until now reports of loss of vision caused by poor blood supply have been sudden and severe, usually occurring in seconds or minutes.

As a result of this report, practitioners are urged to be even more suspicious of circulatory problems in older patients who are slowly going blind.

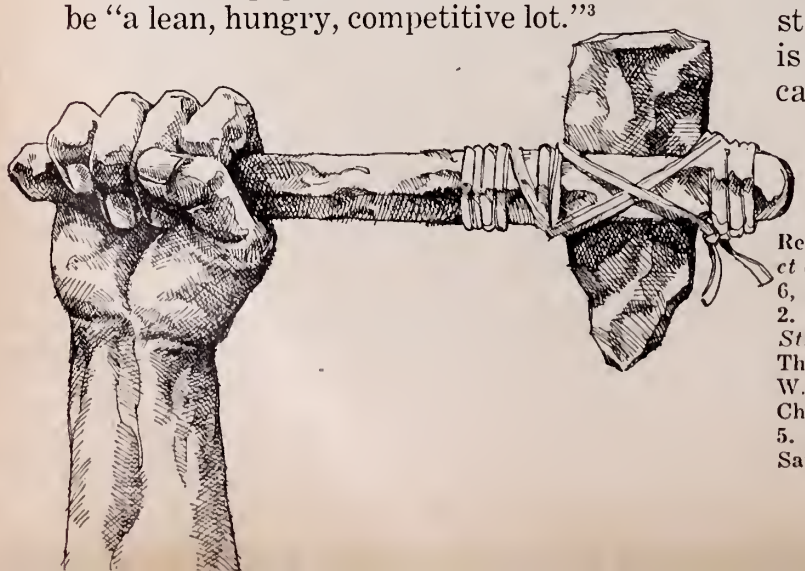
IF MORE MEN CRIE



At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men c
maybe fewer would wind up with duoc
ulcers. But men will be men—the sum tot
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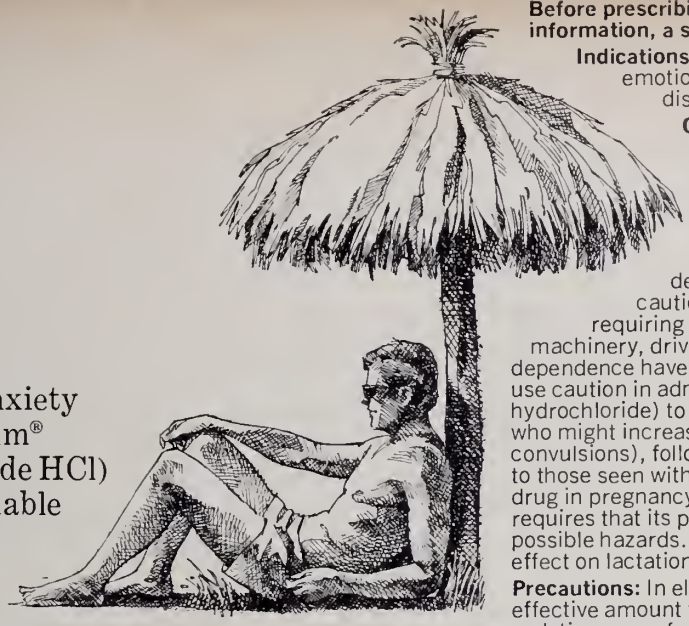


**Take away st
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There is no question that stress pl
role in the etiology of duodenal u
Alvarez[5] observes that many a man wi
ulcer loses his symptoms the day he shu
the office and starts out on a vacation.
problem is, the type of man likely to ha
ulcer is the type least likely to take
vacations or take it easy at work.

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References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe,
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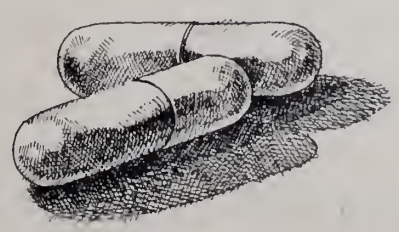


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Librax: It can't change man's nature. But it can usually make it easier for men to cope with the discomfort of stress—both psychic and gastric—that can precipitate and exacerbate duodenal ulcer.
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Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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WARM LINE

clinical management/ drug abuse crises

Practicing physicians can expect to be confronted at almost any time with a medical crisis related to the misuse of psychoactive drug substances. Increasing numbers of people are misusing these drugs and a dramatic increase in the number of drug-related medical crises has been noted during the past several years.

Although much information on this subject has been disseminated, the need for practical advice on basic clinical management of these crises has become greater.

Three physicians, each of whom has had extensive practical experience in dealing with drug abuse problems, have created a series of three-minute audiotapes detailing basic medical approaches to the most frequently encountered drug abuse crises.

Dr. David E. Smith is Director of the Haight-Ashbury Medical Clinic in San Francisco, California, and Assistant Clinical Professor of Toxicology, University of California Medical Center at San Francisco.

Dr. William Abruzzi was Medical Director of both the Woodstock and Powder Ridge Rock Festivals and is currently the College Physician, State University of New York at New Paltz, New York.

Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago School of Medicine, Chicago, Illinois.

Their taped discussions are on automatic telephone equipment for utilization at all times. The opinions given regarding treatment modalities are those of the physician speaking.

Amphetamines	**Dr. David E. Smith**
Hallucinogens	**Dr. William Abruzzi**
Opiates	**Dr. Edward C. Senay**

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Psychosurgery was launched in the 1930's with great expectations. The developments of psycho-tropic drugs in the 1950's, advances in electric shock therapy, and some bad results of lobotomy conspired to cause a decline in the use of psychosurgery. Perhaps this is now due for a revival.

The Renaissance of Psychosurgery*

Granville L. Jones, M.D./Summit

Modern psychosurgery began in 1935 when Egas Moniz did the first lobotomies in Portugal. This procedure enjoyed a heyday in the decade that followed, but then its popularity slowly declined. Perhaps cases were too poorly selected, or perhaps the burgeoning of the newer psychotropic drugs were the factors. And too often, disastrous results were reported. In our hospital (Fair Oaks, Summit, New Jersey) we referred about one patient a year for lobotomy or other psychosurgery, though we saw it as a sort of last resort procedure.

Evidence is now accumulating which suggests that a revival of psychosurgery is in the offing. Last summer an international conference on the subject led to the conclusion that, if we could establish more precise indications and try some of the newer technics, the procedure might be a valuable therapeutic modality. Not only that, but we now have reason to believe that crisp, usable criteria for surgery *can* be established.

This conference in Copenhagen was attended by neurosurgeons, neuropathologists, psychiatrists, and neurophysiologists from 17 different countries, (Not a single doctor came from Portugal, however.) An amazing variety of approaches was described. Technics included not only surgical ablation but electrodessication, electro-cautery, thermal cautery, cryotherapy, and ultrasound. The stereotactic approach was discussed exhaustively and its merits and drawbacks thoroughly explored.

One exciting aspect of this conference was the specific operative treatment for particular symptoms, including aggressive behavior. Here is a procedure which can be selectively applied for management of aggressive criminality.

Scoville of Hartford, in his presentation, pointed out that surgery for mental and emotional illness had been largely limited to the connections with the pre-frontal lobes. He proposed that this be broadened to include connections with other areas. He has had some experience with orbital undercutting and found it useful in depression, in schizophrenia, drug addiction (particularly if the basis is a neurosis), and for obsessive-compulsive phobic neurotics. He did not advocate it for psychopathy or for alcoholics. He proposed that if improvement after electro-convulsive therapy turned out to be temporary, psychosurgery should be given a trial. One of his points was that the surface areas of the brain have little influence on the fundamental mechanisms in mental disease. He suggested that ultimately therapy of a surgical nature will consist of altering rather than blunting functioning of the deeper midline structures.

Dr. Sem-Jacobsen of Oslo discussed depth electroencephalography and stereotactic psychosurgery. He suggested it was possible to

* From the International Conference on Psychosurgery held in Copenhagen in August 1970. Dr. Jones is Clinical Director of the Fair Oaks Hospital in Summit, New Jersey.

localize a target in the frontal lobe and in the region around the third ventricle. He thinks that he can avoid undesirable side effects. He warns that no lesions should be made before the effect of the proposed procedure has been thoroughly studied and evaluated. Several Japanese investigators, Doctors Sano, Sekino, and Mayanagi talked of cases of violent aggressive and restless behavior which were treated by stereotactic procedures. This produced marked calming effect in 95 per cent of the cases. In 41 per cent of the cases of intractable epilepsy, seizures became controllable by medication.

Dr. Hunter Brown of California reviewed production of bilateral lesions in the anterior cingulum for severe affective psychoses and psychoneuroses. He reported considerable success with a simplified surgical approach through a single trephine opening on either side.

Drs. Hetherington, Haiden, and Craig of Canada analyzed neurosurgery in the treatment of affective disorders. In Canada, adverse opinion concerning psychosurgery had developed after the publication of a report a few years ago in which 80 per cent of the patients operated on were schizophrenics. Incidentally, Moniz reported poor results in schizophrenia as far back as 1936. Dr. Hetherington and his group used a modified leukotomy, really an orbital undercutting procedure. None of their patients was schizophrenic. They all had affective disorders. They found that appropriate for psychosurgery were manic depressive patients (with both up and down mood swings), recurrent depressives who respond to electric shock but relapse, and certain patients with severe hypochondriasis and/or tension. Turner of England described a bilateral temporal lobotomy and posterior cingulectomy for the management of aggressive behavior. This behavior, associated with temporal lobe epilepsy is associated with fear, tension, phobias, periods of terror. They treated aggressiveness, hostility, and anti-social tendencies, with or without paranoid features, and found that results are best with patients with good personality in other directions, normal intelligence, and a worthwhile premorbid record. They did not advocate operating on young people (except those with schizophrenia). For schizophrenics they suggest a combination of operation on the frontal lobes and cingulate gyrus.

Drs. Vaernet and Madsen of Copenhagen described stereotactic amygdalotomy and basofrontal tractotomy. They talked of patients with aggressive, destructive behavior and found that bilateral stereotactic electrocoagulation of the amygdala was effective and resulted in the disappearance of or marked reduction of aggressive episodes. Dr. Balasubramaniam and associates from India reported the management of behavior disorders by stereotactic surgery. They did preoperative electroencephalography with depth electrodes in an effort to identify and localize their target. If patients did not do well with amygdalotomy, they did hypothalomotomy with considerable benefit in many cases.

Two Finnish surgeons, (Drs. Laitanen and Vilkki) did bilateral stereotactic cingulotomy on patients suffering from severe anxiety or intractable pain. The operation was carried out through a frontal burr hole by means of a stereoencephalotome. Before coagulation the target area was electrically stimulated with scalp electroencephalographic recording. Some of their patients had anxiety, some phantom limb pain, some compulsive behavior, and/or hypersexual behavior. They report good post operative results.

Three Copenhagen surgeons reviewed 62 cases of cingulectomy by the open procedure. They observed the patients two to ten years after surgery and had excellent to good results in about 75 per cent. These had been suffering from chronic severe phobic, anancastic neurosis, or intractable pain. Patients who had psychosis or psychopathy had poor or bad results. Those who had had classical lobotomy before the cingulectomy tended to have reduction in their intellectual capacity. Excellent results were also reported on 14 patients who had bi-frontal, prehypothalmic

cryolesions with intractable pain or with grave depression. Only one of their patients developed dementia.

Dr. Thomas Ballentine and associates from the Massachusetts General Hospital and from the Wiswall Psychiatric Hospital in Wellsley also reported on anterior cingulectomy. They have done 226 operations on 160 patients. Indications were psychiatric illness unresponsive to other forms of therapy, or, intractable pain not amenable to other surgical procedures. They found the operation to be technically safe and without adverse effect on intelligence or behavior. Improvement of the disabling mood disturbance was observed in 80 per cent of the cases. The general conclusion was that cingulotomy should be considered for any patient with manic depressive illness who does not respond satisfactorily to pharmacologic agents or electro shock.

Two surgeons (Drs. Hans Orthner and F. D. Roeder) from West Germany described methods and results of stereotactic psychosurgery. In their operations, lesions are produced by an inter-connected series of small electrocoagulations, made at strictly calculated distances from each other. They used insulated side electrodes and are certain that their lesions are precisely located. They do both leucotomies and cingulotomies as well as anygdalotomies, thalamotomies and pallidotomies. They have done 104 psychosurgical operations on 52 patients. They conclude that (1) obsessional neuroses and allied conditions have a good chance of recovery without any side effect by leucotomies restricted to the medio-basal white matter of the frontal lobe and (2) hysterical and aggressive behavior is *not* influenced by this procedure. Schizophrenia is not considered a good indication for psychosurgical operations. Two Swiss neurosurgeons, however, found that leucotomy was *not* a particularly effective treatment for aggressive behavior, but in a small group of cases subjected to amygdalotomy, most cases were successful. They used a stereotactic technic.

Drs. Roeder, Orthner, and Muellenr of West Germany presented a paper on the treatment of sexual perversion by an operation on the ventro-medio hypothalamic nucleus, (Cajals nucleus) which some physiologists say is the "sex behavior center." Some of these were unilateral, some were bilateral. They located their electrodes by x-ray control and stimulation of the area. Some of their cases were subject to uncontrollable pedophilic homosexuality. They gained some appreciable increase in self confidence and initiative with no impairment of intellectual capacity, and no tendency to depression. There was improvement in most cases without any marked change in their hormones or spermatozoa. One case of intractable exhibitionism was considered "cured." In most of the other cases the level of control improved, although the inclination to homosexual behavior remained.

Modified lobotomy was reported from the Fulton State Hospital in Missouri. One of the modifications was the "inferomedial operation," intended to remove the excessive emotional or compulsive overlay to symptomatology and relieve tension and agitation. This operation has been done on over 400 patients at the St. Louis State Hospital, and they are in the middle of a 20 year follow up. These patients were rather highly selected as individuals with good premorbid personality, and with the symptomatology of depression, anxiety, obsessionalism, and tension. Results appear to be good. Also under study at the Fulton (Missouri) State Hospital are grossly disabled patients unresponsive to any other form of psychiatric therapy. They are tolerant to high dosages of psychotropic drugs, are severely anti-social, as well as psychotic, and many are in the maximum security ward. Results on 16 cases have been impressive. They feel that this modification of lobotomy will have an important place in the psychiatric armamentarium for the future.

Dr. Geoffrey Knight of London, reported on 600 cases of restricted orbital undercutting operations. They have not had a single death in 450 cases. Post operative epilepsy was reduced to 1 per cent. Harmful changes in

personality did not occur. Depression is favorably influenced in 70 per cent of their cases and good results in 50 per cent of cases of obsessional-neurosis and chronic anxiety.

Dr. Petter A. Lindstrom of the USA gave a paper on a type of leucotomy by the use of ultrasound. He does craniotomies on both sides, applies the ultrasound transducer to the dura, and transverses the pre-frontal area. He has operated on 475 patients. No deaths have occurred and 75 per cent of the patients were improved, including mostly psychoneurotics. Of the psychotics included in the group only 50 per cent had limited, temporary, or no improvement.

Doctors Ralph W. Wadeson, Laurence Faust, and Maitland Baldwin of Washington, D.C., working at the National Institute of Neurological Diseases described a new technic in which they lowered the body temperature by application of cold. Then they injected diphenylhydantoin intravenously. The number of cases is small but the results are very promising. Following the procedure, the patient should be placed in a therapeutic community and given intensive follow-up rehabilitative care to help integrate his or her personality.

Dr. Walter Freeman presented a follow-up of 410 patients suffering from schizophrenia, whom he had followed for at least four years and in some cases more then 30 years. Some were the classical pre-frontal lobotomy, others were transorbital. He found that patients with no more than one year hospitalization prior to surgery showed markedly superior occupational and social adjustment over those who had been hospitalized ten years before operation. His conclusion: "Schizophrenia is a dangerous disease and in certain cases it is safer to operate than to wait."

Doctors Earl Baker and Ross Flemming of Canada, spoke of a group of "hard core" functional psychiatric patients, subjected to a bi-medial pre-frontal leukotomy. Two-thirds had an excellent or satisfactory outcome. The most striking benefit was a decrease in anxiety and tension.. He recommends the procedure for anxiety neurotics as well as pobics, obsessional-depressive reactions, and even schizophrenia.

Dr. Rolf Strom-Olsen of England reported on a group of patients treated by stereotactic tractotomy, utilizing Yttrium 90 seeds. This procedure appeared to be quite effective with only 11 per cent showing trivial symptoms and 2.5 per cent moderate sequelae.

Doctors W. Umback, Y. Kim, and M. Adler of Berlin reported on the treatment of some 64 patients with disorders of behavior, which were treated with stereotactic coagulation in the thalamic area in the lamella medialis and/or the dorso-medial hypothalamus. They found the best results in the psychomotor epileptics who showed considerable improvement with social rehabilitation. In paranoid schizophrenics, pseudo-neurotic symptoms were ameliorated but with some personality deprivation. One of this significant observations was that it takes at least six months to determine the permanent degree of improvement.

Dr. Lothar B. Kalinowsky of New York, who has been active in the field of physiological treatment of psychiatric patients for many years, reported a recent upsurge of interest in the surgical treatment. He considers that some of the problems originally interfering with good results were the personality changes due to frontal lobe damage. Today, modified technics eliminate this, but relapses seem to interfere with satisfactory results.

Doctors H. J. Crow and D. G. Philips of England reported on 103 patients who were treated with multi-focal frontal coagulation operations, using electrodes implanted stereotactically and left *in situ* for six months. These electrodes were used for exploratory stimulation followed by coagulation. They have found, after 18 months, good results in 77 per cent, significant improvement in 11 per cent, and no improvement in 9 per cent.

At this conference steps were taken toward

the establishment of a permanent organization which will consider the practical feasibility of establishing a journal, selecting a time and place for another international conference, and procedures to set up and maintain communication between the workers in this field. Dr. Walter Freeman was designated as the editor for the publication of the procedures for the Second International Conference.

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Proposed Cancer Agency

The American Medical Association has told Congress that the attack on cancer can be most effectively conducted through the National Cancer Institute within the National Institutes of Health, rather than through a separate and autonomous agency.

Testifying before the House Health and Environment Subcommittee, Franz J. Ingelfinger, M.D., editor of the *New England Journal of Medicine* and a member of the Advisory Committee on Medical Sciences to the AMA's Board of Trustees, said that "the effort to cure cancer will have to be a coordinated effort with full involvement of all the National Institutes (of Health).

"There is another compelling reason to retain the cancer program within NIH and that is to keep the NIH intact rather than have it become fragmented into independent agencies. Under the latter conditions the agencies would be competing for support and recognition rather than collaborating for scientific progress. The NIH is generally regarded in the international scientific community as one of the most splendid scientific achievements of the 20th century. To impair the effectiveness of this productive organization would be unwise. The integrity of the NIH should be maintained and increased support provided."

Dr. Ingelfinger expressed opposition to a compromise measure passed by the Senate which would create a new independent Conquest of Cancer Agency within the NIH. He said that the autonomy proposed for such a new agency would "threaten the structure of the National Institutes of Health and impair research efforts in all fields."

Dr. Ingelfinger cautioned against expecting any quick victory over cancer. "We believe . . . that false hopes should not be created and that people should not be led to believe that with enough money and enough effort cancer will quickly be conquered," Dr. Ingelfinger said. "Although many encouraging developments have occurred in the last few years that justify the major national effort proposed in House Bill 10681, much basic research work remains to be done. Everyone should be prepared for steady but perhaps slow progress. We should also recognize that chance discoveries by scientists working in totally different fields may set the stage for significant future progress. This has occurred repeatedly in the history of scientific discovery, and consequently basic scientific research should be allowed a high degree of individuality and spontaneity.

". . . The American Medical Association advocates a program attacking cancer through greatly intensified and coordinated research efforts. We believe that in the interests of the public and in order to avoid any splintering of efforts, the program, adequately funded, should be administered within the National Institutes of Health under a Director having responsibility for all biomedical research."

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Contraindications: Controindicoted in potients previously found hypersensitive to Trobicin. Not indicoted for the treotment of syphilis.

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Warnings: Antibiotics used to treot gonorrheo moy mosk or delay the symptoms of incuboting syphilis. Potients should be corefully exomined ond monthly serologicol follow-up for at least 3 months should be instituted if the diognosis of syphilis is suspected.

Safety for use in infants, children ond pregnont womon hos not been established.

Precautions: The usual precoutions should be observed with atopic individuals. Clinicol effectiveness should be monitored to detect evidence of development of resistonce of *N. gonorrhoeae*.

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*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-B

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
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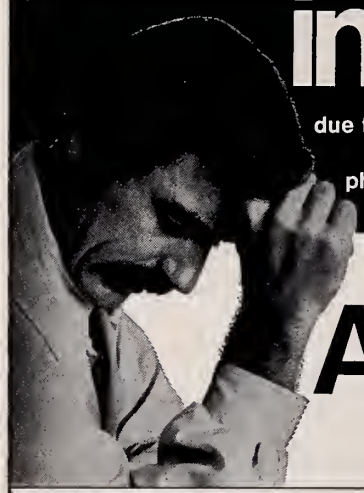
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Spontaneous recovery from a dissecting aortic aneurysm is rare enough to warrant reporting.

Dissecting Aneurysm with Spontaneous Recanalization*

Norman D. Corwin, M.D. and Gerald J. Dolan, M.D./Westwood

A dissecting aneurysm of the aorta is a catastrophic event for the patient. Untreated, survival following such an episode is usually rare. The case here reported is unique in that the patient sustained an apparent acute dissection of the ascending aorta and two days later spontaneously recanalized the lesion, thereby collapsing the dissection.

A 64 year-old married woman was admitted after having experienced precordial and back pain of sixteen hours' duration. The day before admission, she had noted the onset of gradual precordial pain while ironing clothes in the late afternoon. The pain persisted and she took buffered aspirin but this gave but partial relief. It was a warm day and she perspired freely. The pain was intensified by leaning forward, by reclining flat, and by coughing or deep breathing. She did not seek medical attention until the following morning. She had spent a sleepless night with pain which now had moved to the back and later to the epigastrium. The pain did not radiate to either arm. It was not associated with hemoptysis or calf pain. She denied hypertension and stated that she had been told of low blood pressure in the past.

She had had tonsillectomy and appendectomy previously. Her mother had died at 68 with a cerebral vascular accident and hypertension. Her father had died of a carcinoma. The patient herself had a history of rheumatic fever without cardiac involvement at age ten.

On admission her blood pressure was 160/90. Pulse was 100 and regular. Lung fields were clear. Heart sounds were unremarkable. No organs were palpable in the abdomen. Neurological examination was grossly normal. However, the electrocardiogram on admission revealed left axis deviation, QRS of high voltage in standard limb leads, and ST-segment elevation in leads I, II, and AVL, and V2 through V6. T-waves were upright throughout. These changes were compatible with possible left ventricular hypertrophy and acute pericarditis, the latter suggested by the ST-segment elevations. The admission chest x-way (Figure 1) revealed a cardiac silhouette which was not enlarged, but the aorta was prominent in its ascending portion. Its over-all size did not entirely correspond

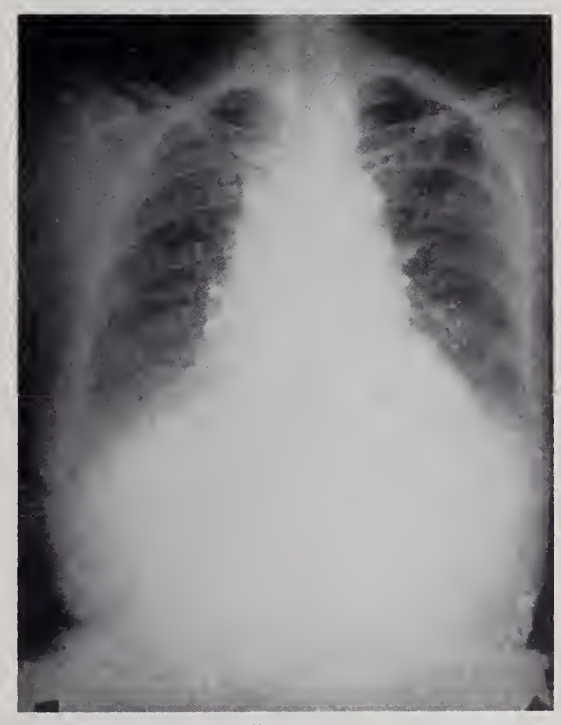


Figure 1

with the visualized calcification in the transverse thoracic portion. The prominence in the ascending aorta suggested the possibility of aneurysmal dilatation. Linear densitites were noted in both lower lung fields compatible with either small areas of plate-atelectasis or old fibrotic disease.

Hemoglobin was 15.5. White blood cell count was 15,100 with 12 per cent lymphocytes. Serology was negative. Fasting blood sugar was 110. Blood urea nitrogen was 12 mg, the cholesterol 230 mg, uric acid 5.2 mg, calcium 8.8 mg, phosphorus 2.7 mg, bilirubin 1.0 mg, direct 0.4 mg, total protein 6.3 Gms, albumin 3.1 Gms, and globulin 3.2 Gms. SGOT was 42 units (normal 8 to 40), LDH 137 units (normal 30 to 120), and SGPT was 6 units (normal 10 to 40). Alkaline phosphatase was 10.5 King-Armstrong units. Urinalysis was completely normal.

Following admission, it was suspected that the patient

*From the Pascack Valley Hospital, Westwood, New Jersey.

might have acute pericarditis. She was treated with opiates for relief of pain and nasal oxygen for her dyspnea.

On the following day, blood pressure in the right arm was 136/90, but the left arm measured 160/100. All cardiac sounds were distant and we heard a soft precordial rub. Coarse rhonchi were audible in both lung fields. No bruits were heard over the neck, thorax, or abdomen. All pulses were present peripherally. Findings were compatible with a dissecting aneurysm of the thoracic aorta. Chest x-ray was taken on the following day, the third hospital day. (figure 2) On



Figure 2

this study, the previously noted dilatation of the ascending aorta was absent. The remainder of the radiographic study was unchanged from that of admission.

The patient's pain had disappeared following the admission and never returned. She remained in the hospital for seven days without further discomfort. She was ambulated and ultimately discharged without incident. The patient has remained in good health thereafter for now nineteen months.

Graham and Millney[1] reported an over-all incidence of dissecting aneurysms of one in 9131 admissions to a general hospital. They cited references to indicate an autopsy incidence of 0.1 to 1.1 per cent at other institutions.

Dissections of the aorta have been classified by DeBakey, *et al.*[2] into three basic types: Type I involves ascending, transverse, and descending aorta. Type II has its origin in the ascending aorta and remains confined to the ascending aorta. Type III has its origin beyond the take-off of the left subclavian artery and the dissection remains confined to the descending aorta.

Type I dissections occurred in 61 per cent of cases at Grady Memorial Hospital.[3] However, in a series of 27 cases,[4] Type II dissections occurred in 70 per cent. The discrepancy is attributed (by the latter authors) to the fact that theirs was a selected series of patients undergoing aortography and they believed that patients with lesions of the ascending aorta usually succumb within a few days.

Type II dissections are seen almost exclusively in patients with cystic medionecrosis of the ascending aorta, also known as Marfan's Syndrome. To the contrary, in idiopathic cystic medionecrosis, as reported by Layman and Wang,[5] aneurysmal dilatation of the ascending aorta rarely presents with a history of chest pain. Patients are seen in congestive heart failure with a wide ascending aorta and aortic regurgitation. They complain of dyspnea and fatigue. Nine of ten such cases were in males.

Castleman[6, 7] says that dissection of an atherosclerotic aneurysm is extremely rare and usually measures but a few centimeters and does not present symptoms. But Braunstein[8] found that most of his subjects had experienced dissection on the basis of arteriosclerosis with but 15 per cent dissecting on the basis of cystic medionecrosis. The role of hypertension *per se* in the pathogenesis of dissection is uncertain since patients with extreme hypertension may have no more medial degeneration than controls of similar age with dissection.

Giant-cell arteritis is a rare cause of dissecting aneurysms,[6] but isolated cases of dissection of the aorta have been found in this condition.[9]

Familial dissecting aneurysm has been reported in a family in which three individuals had cystic medionecrosis without stigmata of Marfan's Syndrome. It was concluded[10] that

Erdheim's disease may occur as an hereditary condition.

Hirst, *et al.*[11] reviewed 505 cases. In this series 30 per cent of the patients died within 24 hours; 60 per cent died within two weeks, and 90 per cent within three months. The causes of death included an extension of the dissecting aneurysm with secondary renal artery occlusion or rupture into the pericardium, mediastinum, or thorax. Jones and Langley[12] estimated that re-entry occurred in 90 per cent of those surviving longer than five weeks. A false channel may become established and sometimes endothelializes, producing a double-barrelled aorta. Austin, *et al.*,[13] in a series of 50 patients who received neither medical nor surgical treatment reported that only 14 per cent were alive at the end of one year.

DeBakey, *et al.*[2] say that with surgical intervention, five year survival could be increased from less than 1 per cent without surgery to 50 per cent survival with surgery. In his series of 179 cases 17 per cent were alive at nine years whereas none were alive in the medically or untreated series as reported by Hirst, *et al.*[11]

In 52 cases at the University of Minnesota[14] from 1955 to 1965, 10 of 26 treated surgically survived. Of 26 treated non-surgically only six were discharged home.

Harris, *et al*,[15] treated 40 patients medically. In this series, one patient died within 15 minutes. Twelve were treated surgically with a mortality rate of 25 per cent, and 27 were treated medically with anti-hypertensive therapy with a 15 per cent mortality. No patient had aortic insufficiency or Marfan's Syndrome. In the patients treated medically, all had a systolic blood pressure in excess of 110.

An isolated case was reported (with two-year survival), in which dissection was complicated with rupture into the pleural space.[16] Here the pleural effusion had cleared and the mediastinal shadow diminished. Complete healing of a dissection of the aorta is very rare but isolated cases have been reported.[17]

In the case reported here, angiographic confirmation was not obtained and the actual course of events remains conjectural. The location of the tear may have been in the ascending aorta but might just as well have been distal with proximal dissection occurring secondarily. It is postulated that she sustained an aortic dissection, and secondly, distal recanalization. Perhaps auto-fenestration occurred spontaneously within 48 hours.

Summary

A 64-year-old woman had precordial and back pain of 16 hours' duration. A discrepancy was noted in the blood pressure taken in the two arms. The electrocardiogram revealed voltage and axis of left ventricular hypertrophy and ST segment elevations suggesting possible pericarditis. Chest X-ray demonstrated a widened mediastinal shadow with calcifications not conforming to that of the widened aortic arch. While being considered for transfer to another hospital (for definitive angiographic study and appropriate therapy), her pain disappeared and the mediastinal shadow diminished significantly and spontaneously. Though unproved, it was felt that the patient had sustained a dissecting aneurysm which spontaneously recanalized thereby collapsing the dissection.

A bibliographic listing of 17 citations may be obtained from the author upon request.

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Diagram of a drug abuser



Redness and watering of eyes
—glue sniffing

Red, raw nostrils
—sniffing cocaine

Running nose
—heroin, morphine, codeine

Profuse perspiration and body odor
—amphetamines

Constant licking of lips
to keep them moist
resulting in chapped raw lips
—amphetamines

Long sleeve garments worn constantly
to hide needle "tracks"
—heroin or methedrine

Drastic loss of weight
—heroin, opium

Tremor of hands
—amphetamines

Sunglasses worn at
inappropriate times and places
hiding dilated pupils—LSD

Staggering, disoriented
—barbiturates

These are a few of the signs that may indicate that a young person could be abusing drugs or using narcotics. While these symptoms are not proof of drug abuse (most could occur for several other reasons), they should serve to alert parents and friends that a problem may exist.

If you're not sure, talk with your family physician. If you suspect, ask your child point blank, "Are you taking drugs?"

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Special Article

Here described is a little-known information retrieval service available to all doctors in New Jersey.

Computerized Literature Searching

Isabel Spiegel, Information System Supervisor
New Jersey College of Medicine, CMDNJ, Newark

If residents, interns, or students need a bibliography of references on a medical, biomedical, dental, or nursing subject, the CMDNJ Library Staff can prepare a printout in a short time at *no charge* via our information retrieval computer terminal. Visit the staff at the CMDNJ Library, Building 3, Interims, Newark, or call (201) 877-4581.

The doctor who has spent valuable time searching the pages of *Index Medicus* for articles on a coordination of subjects, such as a particular drug in the treatment of a specific disease, or case reports of two (or more) coexisting diseases, will be interested to know that a simpler, more accurate, and time-saving method of doing these searches has been developed and the CMDNJ Library's participation in the system is here described. In New Jersey a bibliography can be prepared on a coordination of subjects through an automated system.

An IBM 2740 Communications Terminal, installed in the College Library at Newark in November 1970, ties us into the SUNY Biomedical Communication Network, an on-line, real-time, automated information retrieval system, headquartered at Albany, New York. SUNY stands for State University of New York. This network increases the utility of the citations in *Index Medicus* by making them accessible to a wider portion of the medical community in an easily retrievable form. This is accomplished *via* the leasing, on a monthly basis, of duplicate copies of the MEDLARS** tapes, owned by the National Library of Medicine. The tapes accommodate the SUNY programing and equipment needs and the citations are made available to Network members through their local terminals. (Figure 1)

A search is initiated when a patron needing literature on a medical subject comes to the CMDNJ Library. He fills out an "Individual Search Record" form and is interviewed by a search analyst on the library staff, who must elicit from the user a clear statement of his information needs. The search analyst then translates the patron's request into the terms of the system's controlled vocabulary, Medical Subject Headings (MESH). In addition, the desired relationships among the concepts involved in the search must be established. Next the request is typed into the SUNY system on the terminal typewriter, according to the required program format. It must be entered in letter- and character-perfect form or the search will not be properly executed.

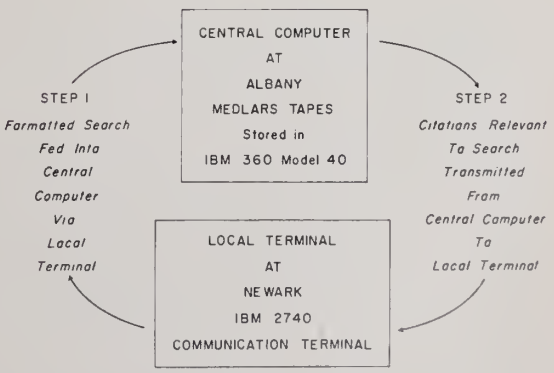


Figure 1—Routes of Communication Between Central Computer and Local Terminal.

Within a short time—usually 5 to 10 minutes the typewriter will automatically start to print out citations to articles relevant to the coordination of subjects in the search request,

** MEDLARS is an acronym standing for Medical Literature and Analysis Retrieval System, the end-product of which is a data-base of citations to medical and health-related literature.

and the procedure is completed by giving the patron the printout of references. (Figure 2)

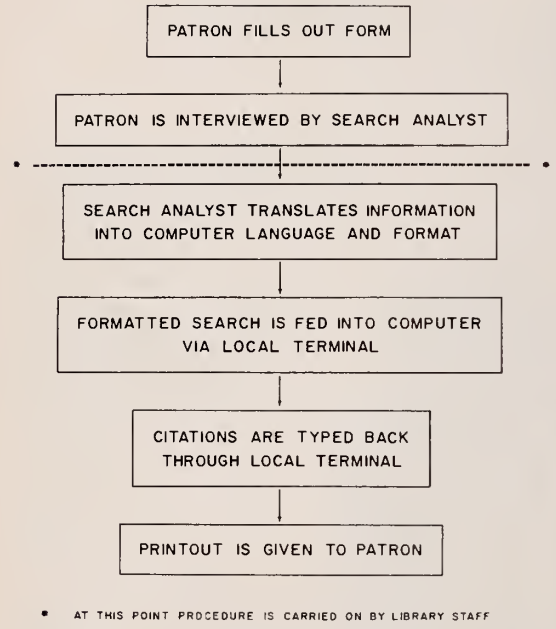


Figure 2—Steps from Initiation to Completion of Search Request.

Searches may be structured in several ways depending on the inquirer's needs. Examples of various types of searches follow:

"And" Search: An example of an "and" search would be: "The Electroencephalogram in Measles." Both the concept, "electroencephalography" *and* the concept, "measles" must be contained in each citation retrieved. The structure would be "electroencephalography and measles."

"And/or" Search: A sample "and/or" search might be: "Prosthetic Replacement of Hip or Shoulder Joint." In this case, the concept of "prosthesis" must be present in each relevant article, but *either* the concept, "hip joint" *or* the concept, "shoulder joint," (but *not necessarily* both) must be contained in each citation printed out. The structure here would be, "(string 1) joint prosthesis and (string 2) shoulder joint, hip joint."

"But not" Search: The patron might be interested in articles on: "Smoking and Lung Cancer, but no Animal Studies." Both the concepts of "smoking" and "lung cancer" must be present in each citation retrieved, but those articles dealing with "animal studies" are not to be printed out. Search structure would be "(string 1) smoking and lung neoplasms and (string 2) animal experiments (not)."

Figure 3 shows the actual printout for the "and" search described in the text, illustrating the form in which the references come through the terminal.

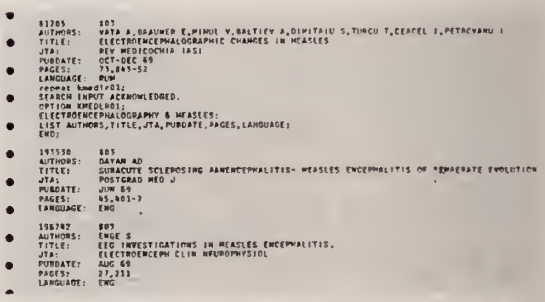


Figure 3—Portion of Printout for "And" Search Described in Text.

Presently, it takes an average of four days from receipt of a search request to put a printout in your hands. If, however, you are in urgent need of information, particularly for patient care, your search will be given priority, and, if necessary, will be run immediately. The four-day time lag is due to a continual backlog of searches, which, in turn, is due primarily to a relatively slow response time on the part of the machine, inherent in the system. As a result of the recent relocation of the computer headquarters to larger facilities and installation of an IBM System 370, model 155, which has ten times the power of the previous one, we anticipate reduction in machine response time, enabling us to complete more searches each day.

CMDNJ paid one fee to the State University of New York for a year of participation in the network, during which time there is no

limit on the number of searches which may be run and no additional fees. We in turn make no charge to patrons for the service.

To date we have completed 533 SUNY searches and generated a total of 24,345 citations. The consensus of the inquirers using the system at CMDNJ seems to be that they are saved considerable time in compiling references they need; they still must go through the standard library channels to acquire those of the documents cited, in which they are interested.

At CMDNJ, we feel a strong responsibility in meeting the medical information needs of the health sciences community outside the College and particularly within New Jersey. As a subregional library of the New York-Northern New Jersey Regional Medical Library, we are committed to making the current medical literature as accessible as possible within our boundaries. Our responsibilities in this endeavor were recently broadened when our library was awarded a grant by the New Jersey Regional Medical Program, to provide library services to physicians in the state, directly, if necessary, but preferably through their hospital librarians.

To meet these commitments, we have been carrying out SUNY searches for any outside library (hospital, academic, society, industrial) or individual, located in New Jersey, having a legitimate need for medical information, provided the search request is suited to the system. This is done with the recognition that the College's faculty, students, interns, residents, and staff are our primary clientele and filling their information needs is our primary concern.

Thus, a physician in need of a bibliography on a medical subject can reach us personally if he is in a great hurry, but we would prefer that he work through his hospital librarian who will screen the request and determine how best to handle it.

Our plans include widening knowledge and awareness of our SUNY terminal and its capabilities among New Jersey health-related librarians, through orientation and training sessions in our libarary. Pairs of interested librarians are invited, during successive weeks, to spend a day with us, becoming acquainted with the network, search formulation, and machine operation.

It's been said before: literature is flooding the field; technology is striving to provide controls. Amidst it all, libraries are getting to be more and more exciting—medical libraries are in the forefront—and the CMDNJ Library is finding the challenge irresistible!

ATTENTION COMPONENT SOCIETIES

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972** at Chalfonte-Haddon Hall in Atlantic City. Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972.**

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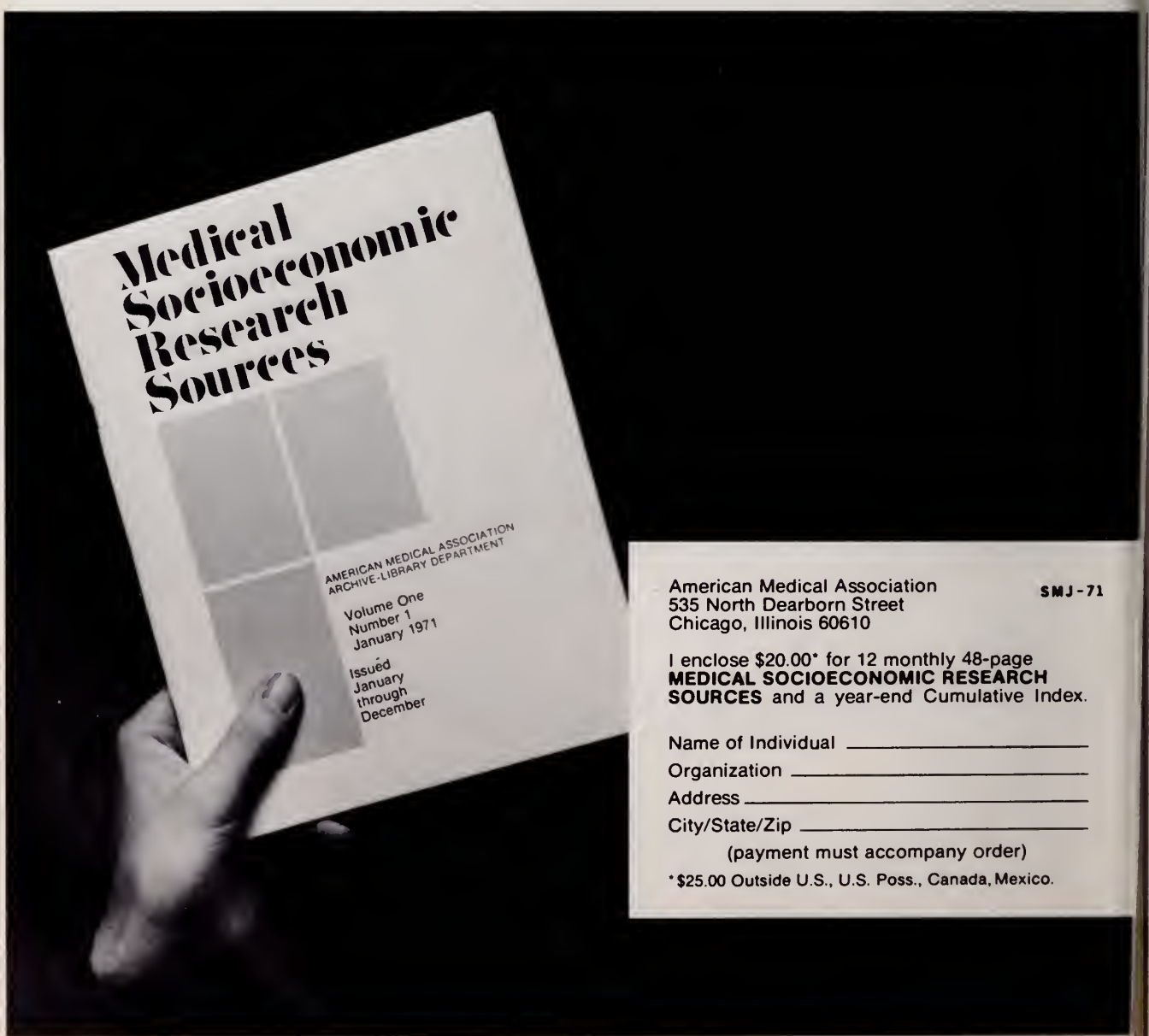
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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

November 21, 1971

A regular meeting of the Board of Trustees was held on November 21, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Rutgers Medical School . . . Thanked Dean Mackenzie of Rutgers Medical School for his informal presentation, calling attention to the following current and long range plans of the College: the Psychiatric Institute building will be opened in the fall of 1972; chairmen have been recruited for the Department of Medicine and the Department of Psychiatry; presently 80 freshmen and 80 sophomores can be accommodated; plans call for third and fourth year clinical training by September 1972; hopefully a three-year curriculum will be instituted by 1976; by 1978 it is planned that 160 M.D.'s each year will be graduated from Rutgers; the College aims to establish affiliations with several New Jersey hospitals for teaching clinical subjects; a separate Department of Family Practice will be established upon approval of Dr. Bergen, President of CMDNJ, and the Board of Trustees of the College.

Executive Offices Building Plans . . . Approved the following recommendation of the Executive Committee and Special Committee on House Maintenance in joint meeting.

That the Board of Trustees approve the final plans and specifications covering the alterations and additions to the Executive Offices of MSNJ. (Requests for bids will be initiated about January 15.)

Blood Banking . . . Adopted the following recommendations relating to the uniformity of blood banking procedures in New Jersey:

(a) That the Governor of New Jersey be requested to establish a Commission to study problems relating to the procurement and distribution of blood in the State of New Jersey.

(b) That upon appointment of the above-mentioned Commission, MSNJ schedule a meeting to prepare testimony for presentation to that Commission. To this meeting should be invited agencies connected with blood collection.

Physicians' Relief Fund . . . Appointed the following members to the Standing Committee on Physicians' Relief Fund:

Joseph J. Kline, M.D., Chairman (3rd District) (1974)
John J. Bedrick, M.D. (2nd District) (1974)
A. Guy Campo, M.D. (5th District) (1973)
Frederick W. Durham, M.D. (4th District) (1973)
Frank Y. Watson, M.D. (1st District) (1972)

B/T Minutes to Past Presidents . . . Approved a suggestion that the last five immediate past-presidents of MSNJ be included among those receiving the minutes of the Board of Trustees' meetings.

Committee to Assist Governmental Health Planning Agencies . . . Adopted the following recommendation, in accordance with a suggestion from the Committee on Child Health and the approval of the Council on Public Health:

That the Board of Trustees of MSNJ establish a special committee whose primary aim would be to assist existing governmental health planning agencies in their activities.

Air Pollution . . . Adopted the following recommendation from the Committee on Environmental Health (which had previously been approved by the Council on Public Health):

That MSNJ urge the New Jersey College of Medicine and Dentistry, the Department of Environmental Protection, and the New Jersey State Department of Health to coordinate their efforts in establishing a project to develop more advanced knowledge of the problem of air pollution and to seek special funds from both industry and the government for this purpose.

Accreditation of Hospitals . . . Adopted the following substitute recommendation for a

recommendation offered by the Council on Public Health:

That MSNJ reaffirm its position to the Joint Commission on Accreditation of Hospitals that an open meeting with the hospital medical staff be a part of every survey procedure.

Council on Public Relations . . . Approved the report of the November 14 meeting of the Council on Public Relations, including the following continuing projects for 1971-72:

1. Publication and distribution of:

(a) *Junior Health Hints* to schools and public libraries.

(b) *Membership Newsletter,* including the annual compilation and distribution of a bound, indexed set to component societies.

(c) *Periodic Newsletter* to cooperating agencies/individuals as required.

2. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

(a) The Eye Health Screening Program

(b) The Annual Meeting

(c) Child Safety Week

(d) Selected official programs and activities

3. Responsibility for bestowal of the Golden Merit Award.

4. Responsibility for the informational center and issuance of press releases at the annual meeting.

5. Encouragement of continuance—or establishment—of orientation programs for new members under the sponsorship of component societies.

6. Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix of Reference Information" of the *Membership Directory.*

7. Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level.

Section on Neurosurgery and Neurology . . . Adopted the following amended recommendation originally suggested by the Committee on Annual Meeting:

That a Section on Neurosurgery and Neurology and a Section on Psychiatry be formed, and that the New Jersey Neurosurgical Society be invited to co-sponsor a program to be presented by the newly formed Section on Neurosurgery and Neurology at the 1973 Annual Meeting.

Affiliate or Adjunct Membership in MSNJ . . . Approved the following recommendation from the Committee on Medical Defense and Insurance for referral to the Standing Committee on Revision of Constitution and Bylaws:

That MSNJ create a new category of special continuing membership, such as "affiliate" or "adjunct," to enable former active members of MSNJ who leave the State to retain membership status with the Society and thereby continue their coverage under its group health, accident, and life insurance policies.

Audit Review . . . Approved, with commendation to the Treasurer and Business Manager, the report of the Special Committee on Audit Review.

Annual Meeting . . . Approved the following recommendation from the Committee on Audit Review:

That the Committee on Annual Meeting be asked to re-examine the high cost areas, especially the costs associated with the Informational Exhibits, the Technical Exhibitors' Buffet, and the Annual Dinner Dance; and that the Committee on Finance and Budget be apprised of and consulted on the Committee on Annual Meeting's deliberations.

Journal . . . Approved the following recommendation from the Committee on Audit Review:

That the Committee on Publication be asked to review the statement and report its findings and/or recommendations to the Committee on Finance and Budget.

Utilization Review and Peer Review . . . Approved the following recommendation from the Joint *Ad Hoc* Task Force (with the New Jersey Hospital Association):

That the State Peer Review Committee and this Joint *Ad Hoc* Task Force be combined by designating the members of the Joint *Ad Hoc* Task Force as consultants to the State Peer Review Committee.

Statewide Automated Bookkeeping System . . . Approved the following recommendation from the *Ad Hoc* Committee on a Statewide Automated Bookkeeping, Accounting, and Billing System and directed that the Committee be discharged with thanks:

That the Statewide Automated Bookkeeping, Accounting, and Billing System not be established.

Note: The above recommendation was the result of a survey of the component county societies which indicated a lack of interest in such a system.

Peer Review . . . Approved the following Presidential appointments to the State Peer Review Committee:

1st District	George L. Benz, M.D. Hillel M. Ben-Asher, M.D. (alternate)
2nd District	Thomas C. DeCecio, M.D. James A. Rogers, M.D. (alternate)
3rd District	John A. Lincoln, M.D. Karl T. Franzoni, M.D. (alternate)
4th District	William R. Muir, M.D. Earl B. Keller, M.D. (alternate)
5th District	Louis K. Collins, M.D. Sherman Garrison, M.D. (alternate)
Consultants	Louis F. Albright, M.D. Arthur Bernstein, M.D. John S. Madara, M.D. Nicholas E. Marchione, M.D. James A. Rogers, M.D. Mr. Jack Owen

Blood Procurement . . . Directed that a crash program of advertising in the daily newspapers of New Jersey, suggesting that December is an especially appropriate time to express good will toward one's fellowman by donating blood, be implemented under the guidance of the public relations firm of Daniel Edward, Inc., and that simultaneously the idea of an ongoing, year-round program of blood procurement be referred to the Council on Public Relations for adoption as a regular continuing project, and that all component societies be informed of this action by special notification.

Comprehensive Health Planning . . . Pointed out (in reply to a communication from the Hudson County Medical Society to the effect that there was a lack of communication between MSNJ and its component societies in regard to the Comprehensive Health Planning Council) that the Comprehensive Health Planning Council is a state agency and that MSNJ is not part of its operation, and that the Council has no obligation to inform the Society of its activities. The Society does have representation on the Council in the person of Nicholas E. Marchione, M.D., and there are other M.D. members of the Council: Stanley S. Bergen, Jr., M.D., Alvin A. Florin, M.D., and William T. Snagg, M.D. Samuel J. Lloyd, M.D., serves as an alternate member for the Commissioner of the Department of Institutions and Agencies.

New Health Insurance Proposals

HEW Secretary Elliot Richardson has revealed a new proposal "to tighten controls on provider costs and inefficiences." He outlined the long-awaited program for regulating private health insurance companies. In a 38-page statement, Richardson was critical of the Kennedy-Labor bill. He promised that the provider controls and the insurance company plan will be submitted in legislative detail to the House Ways and Means Committee shortly. Here is a summary of the Administration's text on the provider plan:

In order to help the consumer become a prudent buyer in the medical care market and to protect the consumer against unnecessary increases in health care costs, we shall propose the following:

(1) The states shall require health insurance companies to inform prospective policyholders as to benefits, exclusions, premium costs, and delivery system choices.

(2) The states shall require providers to inform the public as to charges for standard items and other patient access matters.

(3) We will establish local quality review organizations of outside medical experts, including non-providers in some instances.

(4) We propose to require NHISA carriers to apply control measures and statistical reporting measures including review of utilization of health care services. Specific plans for implementation with regard to wages and prices will be developed in conjunction with the Committee on the Health Industry established by the President under Phase II of his new economic policy.

(5) State planning agencies will be required, in cooperation with area-wide planning agencies and as a condition of Federal grant support and approval, to identify areas of physician and facility oversupply. States are to develop and apply detailed criteria based on Federal guidelines, and publish this information.

Under the proposed insurance company regulations, Richardson added that we intend to secure agreements with states under which the states will:

(1) Require annual, independent audits of participating insurance companies.

(2) Create state health insurance insolvency mechanisms. A Federal mechanism will also be established for use if a state fails to act satisfactorily.

(3) "File and use" procedures for premium rates under NHISA insurance contracts, with authority to disapprove extraordinary rates.

(4) Require disclosure by insurers of their administrative expenses as a percentage of premiums.

(5) Create state insurance pools, open to small employers, the self-employed, and those who are not employed, but are ineligible for Federally-financed health programs."

Richardson said he was certain the hearings "will culminate in a national health insurance program." The Administration's plan avoids the danger of two extremes—proposals that do little to alter the present system and proposals to substitute a monolithic Federal scheme, he declared. Richardson said proponents of the Kennedy-Labor bill "seem to assume that radical intervention by the Federal Government in health care, in an inflexible, predetermined, and monolithic manner, is the only way to solve health organization and delivery problems. I suggest that we are more likely to attain our common health objectives by stimulating competition and by promoting consumer education and freedom of individual choice, rather than by resorting to fiscal coercion and unrealistically global schemes." He estimated it will cost $60 billion in new taxes.

The American Medical Association's Medicredit and the Health Insurance Association of America's plan also were criticized. The major shortcoming in both, said Richardson, "is the great unlikelihood of achieving universality in protection."

The catastrophic protection plans, standing alone, "do very little for very few people—far less than what this nation must do if it is to act with a full sense of responsibility," the HEW Secretary testified.

With the Administration's testimony in hand, the Committee then turned to the long parade of witnesses from such diverse organizations as the College Democratic Clubs of America to the Senior Citizens Golden Ring Council to ascertain how they think the nation's health care system should be reshaped.

AFL-CIO President Meany told Committee members that "Labor will vigorously oppose" any efforts to dilute its plan for national health insurance.

"I hope and firmly believe that we won't have to come back in the next Congress," Meany said. "But, if we have to, we will come back again and again until the Health Security Program is enacted. And, if we have to, we will take this issue to the people in the elections of 1972."

Meany blasted the national health insurance proposals of the Administration, the health insurance industry, and the AMA saying they "would all just pour new money into the present health care delivery system which is a failure." He said that AMA's Medicredit "represents a major shift in direction for organized medicine . . . but it is little more than a continuation of the present unsatisfactory system of delivering health care."

Meany scoffed at warnings that physicians might rebel if the Labor Bill is enacted. "The vast majority of doctors are dedicated, proud professionals whose basic concern is for the sick and ailing."

The American Farm Bureau Federation urged against the creation of "a powerful bureaucracy of great scope," and the National Federation of Independent Business came out flatly against any compulsory insurance system.

The American Public Health Association called for a broad national program with heavy emphasis on speeding development of prepaid group plans. The goals set forth by James Kimmey, APHA Executive Director, fit

the Labor Bill more than any other proposal, but the association did not endorse a single measure.

Replying to charges private companies have failed to stem rising costs, J. Henry Smith, President of Equitable Life Assurance Society, said that the principal causes have been rising wages, more costly equipment, and expensive new life-saving technics. He asked whether insurers were supposed to prevent these developments. Furthermore, the witness said, "Insurers have tried hard to spot and control overcharging. We have worked with medical societies to set up peer review committees, not just for the purpose of catching overcharges but for the purpose of educating physicians not to overcharge in the first place."

Leonard Woodcock, President of the United Auto Workers Union, told the Committee, "it is time to cancel the insurance industry" and impose a national health insurance program operated by the government. Woodcock opposed the Administration's proposal to require employers to provide employees with health insurance from private firms, saying organized labor helped to create the private health insurance industry and supported it for three decades. "But the private health industry has failed," Woodcock said. "It has failed to control costs. It has failed to provide adequate benefits even for those with some form of coverage. After 30 years of effort, all private health insurance combined still covers only a little more than one-third of private personal health care expenses."

Pharmacists, represented by the American Pharmaceutical Association, urged the Committee to include drugs in any health insurance plan.

William G. Battaile, President of the American Association of Blood Banks, asked that no coverage be provided to pay for blood transfusions. He contended that payments would encourage greater use of commercial blood banks and increase the risk of hepatitis.

The Eye and Learning Disabilities

The eye and visual training in the treatment of dyslexia and associated learning disabilities have recently been reviewed with the following conclusions by the American Academy of Pediatrics, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology:

1. Learning disability and dyslexia, as well as other forms of school underachievement, require a multi-disciplinary approach from medicine, education, and psychology in diagnosis and treatment. *Eye care should never be instituted in isolation when a patient has a reading problem.* Children with learning disabilities have the same incidence of ocular abnormalities—refractive errors and muscle imbalance—as children who are normal achievers and reading at grade level. These abnormalities should be corrected.

2. Since clues in word recognition are transmitted through the eyes to the brain, it has become common practice to attribute reading difficulties to subtle ocular abnormalities presumed to cause faulty visual perception. Studies have shown that *there is no peripheral eye defect which produces dyslexia and associated learning disabilities.* Eye defects do not cause reversals of letters, words, or numbers.

3. No known scientific evidence supports claims for improving the academic abilities of learning-disabled or dyslexia children with treatment based solely on: (a) visual training (muscle exercise, ocular pursuit, glasses), or (b) neurologic organizational training (laterality training, balance board, perceptual training). Such training has frequently resulted in unwarranted expense and has delayed proper instruction for the child.

4. Excluding correctable ocular defects, glasses have no value in the specific treatment of dyslexia or other learning problems. Unneces-

sary prescribed glasses may create a false sense of security that may delay needed treatment.

5. The teaching of learning-disabled and dyslexic children is a problem of educational science. No one approach is applicable to all children. A change in any variable may result in increased motivation of the child and reduced frustration. Mental level and psychological implications are contributing factors to a child's success or failure. Ophthalmologists and other medical specialists should offer their knowledge. This may consist of the identification of specific defects, or simply early recognition. The precursors of learning disability can often be detected by three years of age. Since remediation may be more effective during the early years, it is important for the physician to recognize the child with this problem and refer him to the appropriate service, if available, before he is of school age. Medical specialists may assist in bringing the child's potential to the best level, but the actual remedial educational procedures remain the responsibility of educators.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during November 1971:

	1971 November	1970 November
Aseptic meningitis	7	30
Primary encephalitis	0	3
Post-infectious encephalitis	0	0
Hepatitis: Total	344	279
Infectious	254	216
Serum	90	63
Malaria: Total	9	2
Military	9	2
Civilian	0	0
Meningococcal meningitis	2	8
Mumps	83	219
German measles	38	28
Measles	58	11
Salmonella	65	90
Shigella	47	41

Smallpox

As most of you know, the U.S. Public Health Service has recently suggested that routine vaccination against smallpox be abandoned. Reasons for that decision are as follows:

(1) There have been no cases of smallpox in the United States since 1949. Cases in the United States can occur today by importation only.

(2) The risk of importation of smallpox has significantly declined in the last four years because of the progress made in the World Wide Smallpox Eradication Program commenced in 1967. In June 1971, only nine countries reported smallpox. In 1970, there were fewer than 50,000 cases of smallpox reported from throughout the world.

(3) It is calculated that with this incidence of smallpox in the world, the United States could expect only one importation every 12 years.

(4) Eighteen importations of smallpox have occurred in Europe since 1961. Based on this experience certain conditions emerge about the spread of smallpox after importation.

(a) Smallpox does not spread rapidly.

(b) In the last five years, the average imported case resulted in ten other cases and 0.5 deaths and was controlled in 1.9 generations.

(c) Based on the European experience it would take 15 importations per year into the United States to equal the mortality currently associated with the smallpox vaccination.

(5) Between five and ten deaths per year occur in the United States as a direct result of smallpox vaccination. Several hundred cases of eczema vaccination, generalized vaccinia, and accidental infection occur each year.

The New Jersey State Department of Health concurs with the U.S. Public Health Service recommendation on smallpox vaccination. We will no longer be supplying smallpox vaccine through the biological distributing stations. We are available to answer any question that may arise about smallpox vaccination policy.

ANNOUNCEMENTS

Patients Acceptable in OLAR Training Program

An approved residency-training in otology and laryngology has been accredited through the United Hospitals of Newark. This is the only such program in New Jersey and has affiliation with the New Jersey Medical College. Accepted are your patients who need the services of a hearing center, a speech unit, head and neck surgery, and clinical work in laryngology and otology. Director of the program is Myron J. Shapiro, M.D., 22 Ball Street, Irvington, New Jersey 07111.

Clinical Application of Basic Sciences

In the "Clinical Application of Basic Sciences" series offered by the Burlington County Memorial Hospital, and supported by an educational grant from Merck, Sharp and Dohme, the following programs have been announced for February. The Academy of Family Practice gives one and a half credits per session.

February 3	Antidiuretic Hormones
February 10	Neurological Complications of Visceral Carcinoma
February 17	Full Time and Voluntary Staff—The Interface
February 24	Community Health

Meetings convene at 3:30 in the T. J. Summey Building of the hospital. Additional information may be obtained from the Department of Medical Education, Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly, New Jersey 08060.

Eye Surgery Program

The forty-fifth annual New York Eye and Ear Infirmary Clinical Conference will be held May 4 and 5, 1972, at the Biltmore Hotel in New York City. The program will include: complications in cataract surgery; complications in muscle surgery; complications in retinal detachment surgery; newer trends in eye plastic surgery; refraction problems; glaucoma—complications and management; and selected free papers by alumni and resident staff. The registration fee is $50 (luncheon included), residents $25. For information please write to Conference Registrar, Alumni Association, New York Eye and Ear Infirmary, 310 East Fourteenth Street, New York, New York 10003.

Film for Physical Therapists

Geriatric Pharmaceutical Corporation has made available prints of a 16 minute, 16 millimeter, color and sound film entitled, "Decision." The film is tailored to students at the high school or early college level, and portrays the background and activities of the physical therapist. It follows the therapist through his professional training and practice, in the classroom, in the hospital, in the office, and in the home. The film is non-commercial, no products or devices are advertised or recommended.

"Decision" will be helpful to therapists who are called upon by civic and other groups to talk about their work. It generates a lively "question and answer" period after its viewing. The film is useful to administrators and educators for viewing by students who might be interested in a career in physical therapy.

Arrangements for booking on loan can be made by writing to Mr. Gustave Bardfeld, Director of Clinical Research, Geriatric Pharmaceutical Corporation, 397 Jericho Turnpike, Floral Park, New York 11001.

LETTER TO THE JOURNAL

Thyromimetic Medication

November 23, 1971

Dear Doctor Davidson:

Repeated autopsy findings of minimal atherosclerosis in hyperthyroid subjects have led some clinical investigators to institute thyroidal substance regimes as a preventive. About five years ago the synthetic dextroisomer of thyroxin (DT4) was pharmaceutically introduced as a cholesterol-level-lowering agent. Numerous publications express doubt about the synthetic's advantage over the natural hormone, levothyroxin (LT4). It is reported by some that unwanted calorigenic, autonomic, and cardiotropic effects are as frequent with DT4 as with LT4.

Additional reports have postulated that some fraction of administered DT4 is either converted to LT4 or gives rise to the same thyromimetic metabolites *in vivo*. J. Roche and R. Michel (*Prog. Hormone Res.*, 12: 591, 1956) administered either isomer to rats and recovered the thyroidally active thyropyruvic acid (TPA) from bile and urine.

D. Gage of New York University Biology Department has confirmed and elaborated the findings which will be of interest to physicians. In a paper for the American Chemical Society's meetings he shows that not only subcutaneously administered DT4, but even that merely mixed with minced liver will form TPA. The conversion of TPA to the naturally occurring TD4 is then a simple transaminase reaction that could be carried out by the serum glutamate-pyruvate enzyme familiar to us as the "SGPT."

Such "academic" researches go far to explain why patients on DT4 do experience, qualitatively at least, the same sweating, flushing, and palpitation as do those who are ingesting (for them) excessive doses of dessicated thyroid, and the whole matter raises the question of wherein any real advantage of DT4 resides.

(Signed) Robert D. Barnard. M.D.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1972
January

11 **Academy of Medicine of New Jersey**
Bloomfield
Sectional Meeting: Dermatology

12 **Bergen Pines County Hospital**
Paramus
Coronary Artery Disease

13 **Academy of Medicine of New Jersey**
Carriage Trade, East Orange
Venereal Disease Today

13 **Burlington County Memorial Hospital**
Mount Holly
Current Concepts of Cardiomyopathy

13 **Academy of Medicine of New Jersey, American Academy of Pediatrics, and Bristol Pharmaceutical**
Children's Hospital, Newark
TB and Resp. Diseases in Children

19 **Academy of Medicine of New Jersey**
College of Medicine and Dentistry at Newark
Advances in Radiotherapy

19 **Bergen Pines County Hospital**
Paramus
Clinical Prospects of Prostaglandins

20 **Academy of Medicine of New Jersey**
Fairlawn Memorial Hospital
Saddlebrook
Diagnosis and Treatment of Shock

20 **Burlington County Memorial Hospital**
Mount Holly
Current Trends in the Therapy of Mild Hypertension

20 **Fair Oaks Hospital**
Summit
Polyamines in Mental Disorder

26 **St. Clare's and Dover General Hospitals**
Fluid and Electrolyte Balance

26 **Bergen Pines County Hospital**
Paramus
Parkinson's Disease

27 **Academy of Medicine of New Jersey**
Jewish Hospital, Jersey City
Renal Failure

27 **Burlington County Memorial Hospital**
Mount Holly
Orthostatic Hypotension

27 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

February

2 **Bergen Pines County Hospital**
Paramus
CPC Meeting

3 **Burlington County Memorial Hospital**
Mount Holly
Problems Related to Antidiuretic Hormones

3 **Fair Oaks Hospital**
Summit
Trace Metals in Mental Disorder

9 **St. Clare's and Dover General Hospitals**
Renal Failure

9 **Bergen Pines County Hospital**
Paramus
Infectious Diseases I

9 **Academy of Medicine of New Jersey**
Columbus Hospital, Newark
Proper Use of Antibiotics

10 **Burlington County Memorial Hospital**
Mount Holly
Neurological Complications of Visceral Carcinoma

16 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Newer Concepts of Hepatitis

16 **Bergen Pines County Hospital**
Paramus
Infectious Diseases II

17 **Burlington County Memorial Hospital**
Mount Holly
Full Time and Voluntary Staff—The Interface

17 **Fair Oaks Hospital**
Summit
Legal Psychiatry

23 **St. Clare's and Dover General Hospitals**
Auto-immune Aspects plus Transplantation

23 **Bergen Pines County Hospital**
Paramus
Infectious Diseases III

24 **Burlington County Memorial Hospital**
Mount Holly
Newer Approaches to Community Health

24 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

March

1 **Bergen Pines County Hospital**
Paramus
Interstitial Lung Diseases

2 **Burlington County Memorial Hospital**
Mount Holly
Sterilization and Therapeutic Abortion

2 **Fair Oaks Hospital**
Summit
Encounter Group

6 **Academy of Medicine of New Jersey**
Valley Hospital, Ridgewood
Diagnosis and Treatment of Shock

8 **St. Clare's and Dover General Hospitals**
Renal Vascular Hypertension; Malignant Hypertension

9 **Burlington County Memorial Hospital**
Mount Holly
Family Life Problems in Medicine

14 **Academy of Medicine of New Jersey**
South Amboy Memorial Hospital
South Amboy
Renal Failure

16 **Burlington County Memorial Hospital**
Mount Holly
Geriatric Psychiatry

16 **Fair Oaks Hospital**
Summit
Legal Provisions for Mental Health

22 **St. Clare's and Dover General Hospitals**
Secondary Nephropathies

22 **Academy of Medicine of New Jersey**
University of Pennsylvania Hospital
Philadelphia
Clinical Gastroenterology

23 **Burlington County Memorial Hospital**
Mount Holly
Alcohol: The Unglamorous Addiction

30 **Burlington County Memorial Hospital**
Mount Holly
Descent into Hell

30 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

30 **Fair Oaks Hospital**
Summit
The Expert Witness

April

6 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

10 **Academy of Medicine of New Jersey**
Saint Francis Health Center
Jersey City
Proper Use of Antibiotics

12 **Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: Implantology

13 **Burlington County Memorial Hospital**
Mount Holly
Thermography

13 **Fair Oaks Hospital**
Summit
Behavior Therapy

19 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Leukemia and Lymphoma

20 **Burlington County Memorial Hospital**
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases

22 **American Cancer Society**
Rutgers Medical School, Piscataway
Role of Primary Physician in Cancer Patient

25 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Current Burn Treatment

27 **Burlington County Memorial Hospital**
Mount Holly
Diseases of the Esophagus

27 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

27 **Fair Oaks Hospital**
Summit
Behavior Therapy

May

4 **Burlington County Memorial Hospital**
Mount Holly
Syndrome of Stress Ulcer

6-9 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

11 **Burlington County Memorial Hospital**
Mount Holly
Zollinger-Ellison Syndrome

11 **Fair Oaks Hospital**
Summit
Brain Tumors

OBITUARIES

Dr. G. Homer Bloom

A past-president of the Warren County Medical Society, G. Homer Bloom, M.D., died on November 6, 1971, at the age of 75. He was a 1971 alumnus of the medical school of the University of Maryland.

Dr. Bloom was chief of surgery at the Warren Hospital in Phillipsburg in the 1930's, and then became chief of staff at the same hospital. He was a Fellow of the American College of Surgeons.

Dr. Paul Cohen

Born in 1903, Paul Cohen, M.D., of Camden, died on September 29, 1971 at the age of 68. He was a graduate of the medical school in Lausanne, Switzerland, class of 1934, and was a well-known family doctor in southern New Jersey. Dr. Cohen was active in the American Academy of Family Practice, and during World War II was a captain in the Medical Corps of the Army of the United States.

Dr. Harold P. Coxson

Born in 1903, Harold P. Coxson, M.D., a member of our Camden County Medical Society, died on November 29, 1971, at the age of 68. He earned his M.D. degree at Temple in 1929 and was affiliated with the Cooper Hospital in Camden. Dr. Coxson was a prominent south Jersey general practitioner, and was active in the affairs of the American Academy of Family Practice.

Dr. John J. Lee

One of the leading family doctors of West Essex, John J. Lee, M.D., died on May 5, 1971. Born in 1896, he received his M.D. degree at the medical school of Georgetown University in 1931. He served the people of Orange and vicinity for 35 years. Before his retirement in 1967, Dr. Lee was affiliated with St. Mary's Hospital in Orange.

Dr. Charles Lipshutz

In 1966, Charles Lipshutz, M.D., of our Hudson County Medical Society, retired, because of illness, from his busy ophthalmology-otolaryngology practice. He was graduated from the medical school of the Unversity of Virginia in 1929 and was on the staffs of both the Bayonne Hospital and the Jersey City Medical Center. Dr. Lipshutz died on June 29, 1971 at the age of 69.

Dr. Alfred Neumann

On the last day of October, 1971, Alfred Neumann of Linden died at the age of 70. Born in Germany in 1901, he earned his M.D. degree at Wuerzburg in 1926. He did family practice in his native country until 1937, when he came to the United States. Dr. Neumann was affiliated here with the Beth Israel Medical Center in Newark and the Elizabeth General Hospital. He was a member of our Union County Medical Society and did general practice in Linden. At one time he was a member of the Linden Board of Health.

Dr. Anthony J. Perrotta

One of New Jersey's senior anesthesiologists, Anthony J. Perrotta, M.D., died on December 1, 1971, at the age of 63. A 1933 alumnus of the medical school at the University of Vermont, he came to New Jersey in 1941, and had been on the staff of the Riverview Hospital in Red Bank ever since. Dr. Perrotta was a Major in the medical corps during World War II, and was active in the American and New Jersey Anesthesiological Societies.

Dr. Francis X. Sweeney

Word has been received of the death on September 7, 1971, of Francis X. Sweeney, M.D., a member of our Monmouth County Medical Society. Dr. Sweeney was board certified in physical medicine and rehabilitation, and was on the staff of the Marlboro State Hospital. He was a 1935 graduate of the medical school at Temple University and was a Fellow of the Philadelphia College of Physicians. Born in 1907, he was 64 years old at the time of his death.

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BOOK REVIEWS

Modern Treatment (Vol. 7, #6): **Management of Esophageal Disease,** Theodore M. Bayless, M.D., Editor. New York, Harper and Row, 1970, Pp. 282. Illustrated. ($20 per year, by subscription)

For those who yet believe heartburn results from hiatus hernia, this book is required reading. A collection of brief essays, it completely reviews the latest knowledge of the esophagus; anatomy, physiology, diseases, methods of testing and measurement, medical, and surgical treatment. The concise essays are thorough, written by experts with excellent and recent references.

Symptomatic esophageal diseases keep doctors busy and many "standard" concepts and treatments have been outmoded by a spectacular explosion of information in the past few years. This highly recommended book reads in a few hours and will authoritatively answer any clinical question in this field.

NORMAN RIEGEL, M.D.

Teeth, Teeth, Teeth. Sydney Garfield, D.D.S. New York, Simon and Schuster, 1971. Pp. 448. Illustrated. ($9.95)

This is an encyclopedia of dentistry with many interesting and instructive chapters and excellent illustrations. It is a labor of love that physicians and their families may find worthwhile.

The writing is a bit muddy, the text too verbose in parts, and the couplets at the end of chapters are corny.

I agree with the author that dentistry, as we know it today, will vanish as a profession in a few years. Preventive measures (e.g. anti-enzymes to prevent plaque formations and fluorides to resist decay) will serve to obviate our profession except for those few who will straighten teeth and treat fractures, incidental decay, and gum lesions.

Woodrow S. Monica, D.M.D.

The Mental Health of the Child. Julius Segal, Ph.D., Editor. Rockville, Maryland, National Institute of Mental Health, 1971. Pp. 587. ($5)

This publication is a compilation of reports on programs sponsored by the National Institute of Mental Health. For five dollars it is a valuable addition to any library—lay or professional. The reports reflect relevant trends in child mental health practice. Bertram Brown, the Institute's director, recognizes "the report serves as a reminder of the beginnings that have been made and of what more we can do."

The reports are grouped into four sections: *Prevention,* the first, provides exciting insights into community-based programs for the very young. Again it becomes apparent that a relatively modest investment in early childhood can foster physical and intellectual development and diminish the rate of increase in difference between various socio-economic groups.

The second section reports on *factors that influence* a child's mental health. Here the range is broad and includes research on family communication and child development. The publication reflects little of the recent clinical interest in this area of family diagnosis and therapy.

The section on *diagnosis and treatment* reports on delinquent gangs, suicide in adolescents, addiction, asthma, well-baby care in a disadvantaged area, and more.

The section on the basic studies of *child development* is one-sixth of the total volume. Does this indicate our increasing concern about prevention and implementation of knowledge we already have acquired? One would hope so; however, many of the studies are not reported on after the mid-sixties, making it all somewhat out-of-date.

The recent report of the Joint Commission on the Mental Health of Children should be a stimulus for increased support of such programs reported here, as the Kennedy Commission Report was in the 1960's. Unfortunately, this has not been indicated by the present administration's fiscal policy.

Robert P. Parkin, M.D.

Handbook of Obstetrics and Gynecology (Fourth edition). Ralph C. Benson, M.D., Los Altos, 1971, Lange. Pp. 774

Four editions speak for the popularity of a text of this type in obstetrics and gynecology. An advantage is the quickness in which new technics, e.g., the Gravlee jet washer, may be introduced to the reader. As a handbook it is almost too bulky to fit comfortably in a coat pocket for spare-time reading. While it is not possible to distill the specialty into one volume, the attempt is a worthwhile one. Pages on postnatal exercises and home delivery might be best left to another time and place. As a review for board examinations or to scan while waiting for a hospital elevator that always seems to be going the wrong way, the text is excellent. It gives a logical, concise, and up-to-date review of basic obstetric and gynecologic knowledge.

Gerard F. Hansen, M.D.

Alcoholism and the Law. Frank P. Grad, Audrey L. Goldberg, and Barbara A. Shapiro. Dobbs Ferry, New York, Oceana Publications, 1971. Pp. 312. ($15.00)

This is the fruit of a Columbia University study of this subject. It touches on the many dilemmas of weighing the criminal responsibility of the alcoholic. Is drunkenness a "voluntary" state? If not, should a person who commits a crime while drunk be excused because he didn't "voluntarily" want to do it? There are annually two million arrests for "public drunkenness" in the U.S.A. Is this a crime or a status? Should alcoholics be compelled to undergo in-patient treatment even if they don't want to be hospitalized, and should courts monitor this to decide when it is safe to release the alcoholic? What about the medical preference for confidentiality of the records of an alcoholic? What happens when the information is needed to decide a "custody of children" suit where one parent is an alcoholic—or to decide on criminal responsibility of an alcoholic or on the need for continued treatment?

These are some of the questions toward which the present book offers some answers. As often happens with surveys like this, the text asks more questions than it answers.

Henry A. Davidson, M.D.

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DIRECTOR
Health Services

Rutgers University has a vacancy for a Director of Health Services for its Livingston College campus in Piscataway, New Jersey. The function will be to provide direction for the Student Health Program as well as medical care for student patients. This position requires a medical degree and licensure and a minimum of 1 year internship. Candidates should also have familiarity with public health comprehensive care programs. In addition to medical expertise, the individual must have administrative abilities to plan programs and facilities, administer the center budget and supervise the supportive staff.

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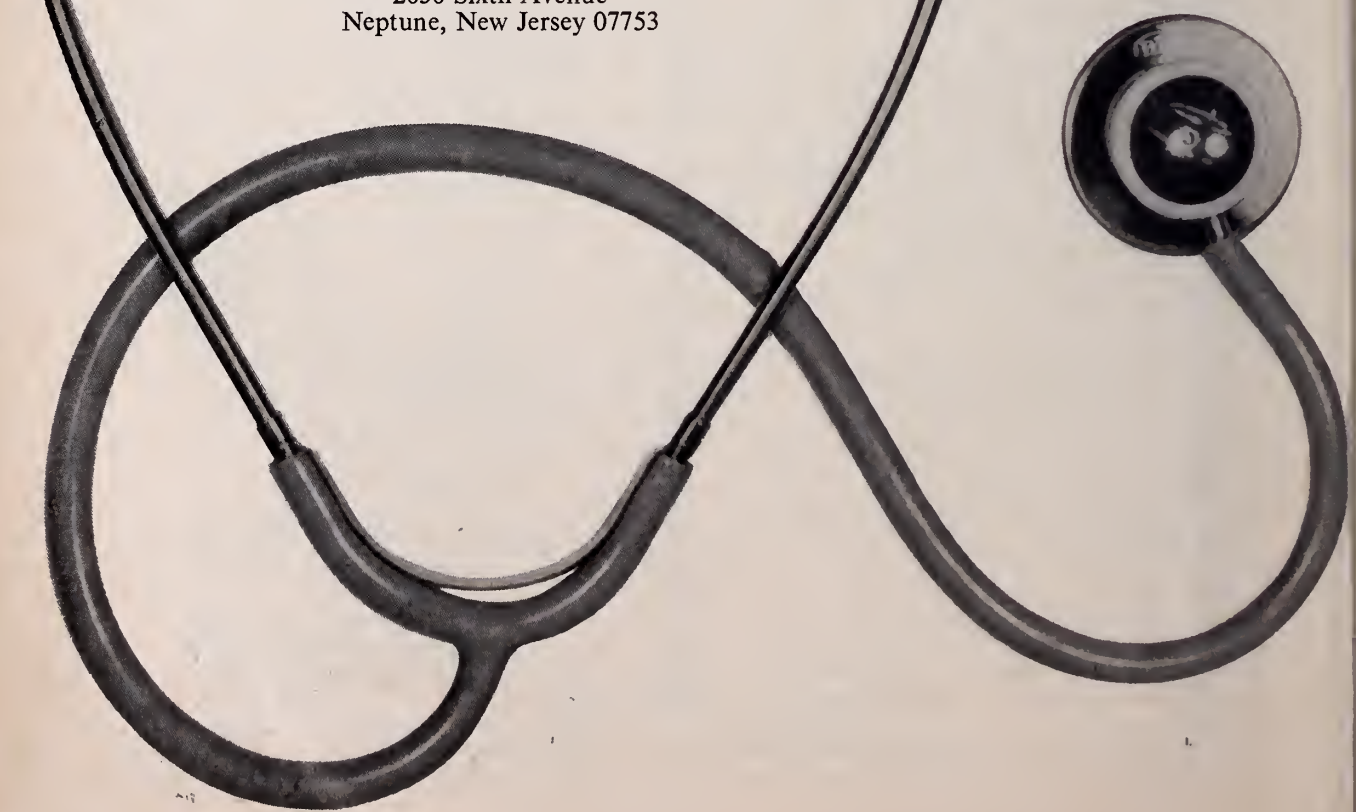
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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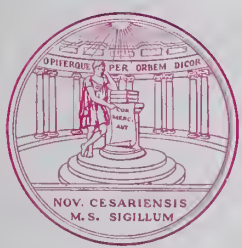
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EDITORIALS

Jesse McCall, M. D. 1906-1972

His many friends were saddened on January 14, 1972, to learn of the unexpected death of Jesse McCall. Born in Virginia in 1906, he was graduated from the Medical College of the University of Virginia in 1931. Actually, he had originally planned a West Point career, and won an appointment to the military academy. Then, coming under the spell of the McCall family doctor, he decided that he, too, wanted to practice medicine. Perhaps medical students who enter the profession by reason of such an identification do make the best physicians. During his post-graduate work, he had a summer residency at the Memorial Hospital in Newton, and this brought him to our state. During World War II, he was a lieutenant colonel and chief of medicine at the Army Hospital on Guadalcanal. He had a term as president of his Sussex County Medical Society. He served from 1952 to 1957 as Treasurer of The Medical Society of New Jersey and in 1960 he became its President. Jesse McCall rendered enormous service to this Medical Society as a Trustee, as President, as AMA Delegate, as Chairman of our Council on Legislation, and, uniquely, as Speaker of our House of Delegates.

The "Speaker's" title is a relatively new one in our annals. The member who fills that job has to exhibit patience, parliamentary skill, good humor, tact, diplomacy, and combine firmness with gentleness. These are qualities that Jesse McCall had in good measure. The House of Delegates' meetings will not seem the same without him. And, as is generally true of doctors who win esteem in organizational activities, he was a good physician. He was board-certified in internal medicine and a Fellow of the American College of Physicians. All of us in the staff and leadership of this Society are forever in his debt.

Medicine As a Social Science—Ltd.

Elsewhere in this issue (page 101) is a paper on lead poisoning in children. This is an illustration of the "social science" aspect of medicine. If tuberculosis is caused by the mycobacterium, then we "cure" the disease by killing the bacillus. Or do we? In the cases here reported, it was not too difficult to detoxify the patient in terms of getting rid of the lead. But when the child returned to the same decaying home, with old paint chips falling off the wall (and some kids eat them like potato chips) the lead poisoning recurred. Is it any of the doctor's business to complain about the old buildings with the peeling toxic paint? Is it the physician's concern if poverty leads to malnutrition, if lack of sex education leads to venereal disease (or is ignorance, maybe, better than knowledge)? Or, does the doctor's duty end with recovery from the acute disease? As an extreme position, this is certainly indefensible. The other extreme—which would make the physician the scapegoat for poverty, bigotry, poor sanitation, and excessive cigarette smoking—is equally indefensible.

It is not always understood that anyone's concern about people in the mass is not the same as compassion about the individual in trouble. It is almost as if there were only a limited supply of this benevolent impulse, and he who diverted it to concern about people by the millions would have less in his reservoir of compassion for individuals for whom he has direct responsibility.

The Sports Physician*

"The diseases we athletes suffer from are subtle," Eamon O'Reilly, the former Georgetown distance runner, was saying the other day. "But doctors treat us like battered bodies just hauled off the football field. Then when

*Abstracted from the *Red Bank Register*

we don't improve they get frustrated and don't want us around the office any more."

O'Reilly, whose time at the Boston marathon last year was the fastest ever recorded by an American, was voicing a common complaint among athletes and especially runners about their present medical care. What they and the doctors are suffering from is the lost art of making a diagnosis, because medicine, as with every profession that gets into specialization, has lost its central art.

Sports medicine has traditionally been the province of the orthopedic surgeon who is by temperament a man of action whose instinct is to cut, inject, or manipulate. His knowledge of total body metabolic and biochemical interrelationships is as sketchy as the medical man's grasp of skeletal stresses and strains. It makes you wonder whether any man be adequate for the job. Perhaps not. A colleague of mine once said, "I'm a specialist because I don't know enough to be a general practitioner." There were, in the old days, such generalists. They were called diagnosticians. When insoluble problems arose, they were called upon to find the thread of truth which ran throughout the apparently contradictory facts, to bring order out of chaos. They were distinguished by their logic, their powers of observation, but mostly by their simplicity. That was the common denominator. The solution when arrived at was so obvious, the wonder was that it wasn't seen right from the beginning.

What this demands is time and wisdom and a life style all out of tune with our times. The patient is willing and wanting and waiting to tell the physician his problem. But if things work out the way delivery of medical care is going, he will be telling his story to a computer. No doctor has the time to listen—to analyze—to diagnose.

A temporary solution was proposed by two Canadian physicians interested in sports medicine. Drs. Tom Fried and Don Shephard, giving up on the possibility of medical schools producing a physician knowledgeable enough to care for the total athlete, recommend that the physician, physiologist, biochemist, and psychologist act as a closely knit team with such technical experts as the physical educator, the coach, and the trainer. To document their brief, the Toronto practitioners report four illustrative case histories: The Runner with the Aching Legs, sidelined for a whole season until it was noticed that his arches were too high rather than too low; the problem of the Breathless Cyclist whose shortness of breath was due to the fact that he keyed his breathing to his pumping action and he overbreathed on hills; the mystery of the Asthmatic Swimmer—it was due to the chlorine in the pool; and the enigma of the Versatile Cyclist—his leg cramps came from the training and racing in pursuit races and distance races at the same time. His spring muscles then cramped up on the hills and in the endurance race.

These four cases can be multiplied by the thousands. There are athletes of all ages and competence being deprived of a literally essential part of their daily life because of the inadequate and superficial approach to their medical care. I doubt that even the team idea will be the solution. What we need is the attention of those great but simple and open-minded men in American medicine. We must direct the laser-like analytical powers of these men to these diseases of excellence, the illnesses of those who pursue the maximum metabolic, muscular, cardiopulmonary, and psychological steady state attainable by man.

Only from such physicians, our current generalists, will we find that sports medicine embraces the study of man from Anatomy to Zen. Only they will tell us the obvious—that resilience, grace, and integrity of the body from foot to brow are necessary. Podiatry and modern dance may mean more than cortisone and the scalpel.

No disease would be too subtle for that team.

George Sheehan, M.D.

ORIGINAL ARTICLES

Newark has the most serious pediatric lead poisoning problem in the USA.

Lead Poisoning in Newark

The Situation Prior To a Case Finding and Intervention Program

Ann A. Browder, M.D./Newark*

Newark recognized an emergency in lead poisoning with three deaths in rapid succession during the spring of 1969. On a population basis, these deaths made the Newark mortality greater than any other city in the USA. The problem relates, at least in part, to the inordinate number of deteriorated and dilapidated buildings. According to the 1960 census,[1] 85 per cent of units with nonwhite heads of household were so characterized. It is augmented by the great prevalence of pica† among the children. Some 30 to 70 per cent of all children attending municipal clinic in deprived areas may be expected to have a history of this oral behavior.[2, 3, 4] Newark is not likely to have a lower prevalence since pica† often reflects the cultural patterns of the rural south and half of Newark's young mothers[5] were born in southern states.

Alarmed by the apparent severity of the problem, the College of Medicine and Dentistry of New Jersey at Newark established an Environmental Toxicology unit in the Department of Public Health and Preventive Medicine, July 1, 1970. A survey was undertaken to assess what has been done and what was known.

Situation Prior to July 1970

Screening in Newark from January 1, 1969 through March, 1970 was carried out by urine analysis using the Davis method** for detection of δ-aminolevulinic (ALA). During this period, 1973 ALA tests were done with 113 positives, a yield of under 6 per cent. Additionally, 833 coproporphyrin (COPR) tests were made of which 21 were positive, a yield of 2.6 per cent. Subsequent blood lead levels on the children with positive urine tests are shown in Table I. Forty-six per cent of the bloods showed lead concentrations of 40 mg per cent or higher. This

Table I

Blood Lead Levels in Children with Positive Urine Screening Tests

Urine Test	Number Positive	Number with Blood Lead Levels 60mg	59-40 mg	40 mg	No Blood Lead Determination
Aminolevulinic acid	113	23	10	45	35
Coproporphyrin	21	2	6	4	9
Total	134	25	16	49	44

means that fifty-four per cent of the bloods taken because the ALA test was positive were considered non-diagnostic. In Newark 94 children were hospitalized for lead poisoning between January 1, 1969 and March 1, 1970, 28 of these as a result of the urine screening program and the other 66 by direct hospital admission. An additional 43 children had blood lead levels 60 mg per cent or higher detected during the screening program, but were not admitted. Many authorities believe the diagnosis of lead poisoning should be made if blood levels exceed 40 mg per cent. If this is used as the upper limit of normal, the number of children with dangerously high levels who were not hospitalized increases from 45 to 65. Thus, the maximum number of children recognized as lead poisoned was 159. In most cases among the 66 hospitalized with symptoms of lead poison-

*The author is Assistant Professor of Public Health at the College of Medicine and Dentistry of New Jersey at Newark.

†Many of today's medical students here never heard of "pica"—a craving for substances not fit for food.

**Bio-Rad, New York City.

ing, the diagnosis of lead intoxication was made promptly by the private physician or hospital staff. But in an important minority the correct diagnosis was not made early in the course of the disability.

The various presenting manifestations in these children, summarized in Table II, account for some of the difficulties in establishing the diagnosis. Delay in recognition and

Table II

Mode of Presentation of 94 Cases Subsequently Treated for Lead Poisoning, Newark 1969

Asymptomatic		
Screening with ALA[1] in urine	26	
Screening with COPR[2] in urine	2	
Case of lead poisoning in relative	7	
Pica	9	
Neurologic symptoms	18	
Convulsions		12
Drowsiness		6
Gastrointestinal symptoms	18	
Vomiting		14
Anorexia		3
Abdominal pain		1
Bone abnormality on x-ray	2	
Anemia	2	
Other, including combinations of symptoms	10	
Total	94	

[1]aminolevulinic acid
[2]coproporphyrin

treatment of this chameleon disease, which masquerades as a common illness of the nervous system, the gastrointestinal system, and/or the bone marrow, can be most serious as is illustrated in the following cases.

A 3 year-old girl had been followed for tuberculous adenitis regularly during the year before her death. During that year she had shown no weight gain. One week before her terminal admission she was treated symptomatically in the emergency ward for persistent vomiting. Four days later an infiltrate was found on a chest x-ray and she was hospitalized for presumed tuberculosis. The vomiting suggested lead intoxication and blood for lead levels was obtained. Treatment was not initiated pending return of the laboratory studies. Three days later she convulsed, and, despite reduction of blood lead concentration from 100 mg per cent to 20 per cent, she died.

The other patient was first admitted for lead poisoning in September 1968. He was treated successfully and discharged. In June 1969 he was seen again with a two-week history of lethargy and convulsions. Medical attention had not been sought during this 14 day period. On admission, hemoglobin was 5.6 gm per cent and the blood lead 190 mg per cent. Despite vigorous therapy, the child died on the seventh hospital day.

The children admitted for therapy generally responded favorably. But, on discharge, they usually face the environment in which they had originally been poisoned. One third of the children hospitalized in this 15 month period were suffering second or third episodes of lead intoxication.

The importance of follow-up of poisoned children is underscored by our cases. Children with lead poisoning clearly cannot be discharged to be seen only if symptomatic. The next episode, if not fatal, is too likely to be one from which the child does not fully recover. Without a specific focus on the dangers of repoisoning, this possibility was usually ignored during the asymptomatic and more reversible stages. When mothers brought a previously poisoned child for care of acute and unrelated conditions, only infrequently was the opportunity used to obtain a blood for lead level determination. The child's fracture, lacerations, abscess, hernia, or common cold was the sole focus of the emergency room physician's attention.

To provide adequate follow-up, the Department of Pediatrics of the New Jersey College of Medicine and Dentistry at Newark established in March 1970 a weekly "Lead Clinic" for children discharged from Martland Medical Unit after admissions for lead poisoning. (Three-fourths of the cases in Newark are cared for in this insitution.) This clinic arranges for these children (together with all members of their household under age 5) to be seen every three months. This is likely to be an interval within which asymptomatic rises in blood lead levels could be appreciated before more serious reactions developed. The follow-up includes review of growth and development, analysis of current symptoms, and determination of hematocrit, hemoglobin, serum iron, and total iron-binding capacity, urinary ALA, and blood lead levels. Pica, past or present, is sought for in the mother and father as well as all children. We made a pre-

liminary study in Newark of the association of pica in parents and children, of 25 cases and 25 control families. Forty-two per cent of the case mothers had pica whereas only 24 per cent of the controls gave this history. Three of the case fathers had pica; none of the control families described this symptom. Although this trend appears interesting, the numbers were small and the differences are not statistically significant.

Siblings of lead poisoned children were usually ignored. Of the children hospitalized for lead poisonings or with blood lead levels 60 mg per cent and over, 60 per cent of the potentially involved siblings (born 1963 through 1968) had neither blood lead nor ALA urine screening done (Table III).

Table III

Results in Known Siblings Born 1963 through 1968 of Children with Blood Leads over 60 mg per cent or Hospital Admissions for Poisoning, January 1, 1969 through March 31, 1970.

	Number of Children	
No blood or urine test performed	54	
Children with evidence of increased body lead	28	
admitted for chelation		14
blood lead 60 mg per cent and over, no admission		4
blood lead 40-59 mg per cent		7
ALA urine positive, no blood lead determinations made		3
Children without evidence of increased body lead (blood lead under 40 mg per cent)	9	
Total	91	

Preliminary Study of Groups of Potentially Lead-Poisoned Children

Under the Division of Epidemiology a summer project to screen children by blood lead levels used two approaches. Initially, a target area was defined by its poor housing conditions and randomly sampled blocks were reviewed systematically by door-to-door search for children age 1 through 5. Subsequently, four "Lead Days" were held in community storefronts, open as a screening service to all who came. The distribution of blood lead levels in children tested by these two approaches is shown in Table IV. More than a third of the children had blood leads above 40 mg per cent; over 7 per cent exceeded 59 mg per cent.

Although a substantial number of lead poisoned children have been identified, the figure for those actually poisoned is presumably much higher. It is estimated[2, 6, 7, 8] that 3 to 8 per cent of children under age 5 residing in city slums have blood leads 50 mg per cent or higher. Newark has a major problem with housing, with 85 per cent of families with nonwhite heads of household living in deteriorated or dilapidated housing in 1960. Since 1960, the ratio of blacks in the population has almost doubled. Currently over 8500 infants are born each year to Newark residents creating a population of children between age 1 and 5 of over 40,000. According to preliminary screening, the number with excessive body burdens of lead is likely to be in the 13,000 range, constituting a public health problem of the first magnitude.

Spanish-speaking families with lead poisoning have been infrequently noted in Newark. Few children with Spanish family names appear among the 94 hospitalized despite the fact that in 1967 Newark was estimated to have a Spanish-speaking population of 12 per cent.[5] This probably does not reflect differences in housing. It *may* reflect a lesser amount of pica in this group. The most likely explanation, however, is that few Spanish-speaking children have been hospitalized because this group receives even less medical attention than the rest of Newark.

The screening program conducted by the Newark Division of Health during 1969 and into 1970 was based on aminolevulinic acid determination. The low yield of true positives, and the high rate of false positives among these urine tests (compared to blood lead levels as standards) reflect both the limits of the procedure and the difficulty of carrying out suitable collections. The specimens should be from the first voiding of the day corrected to proper pH and either stored fro-

zen or studied promptly. None of these requirements is met easily either by the average household or the usual screening programs. Large-scale programs in Chicago and New York City have not used urine ALA as the screening procedure, but have instead focused on blood concentrations.

The small proportion of those at risk who did receive screening (less than 7 per cent) emphasizes the need for wider educational efforts. Clearly, the delay in recognition is not only due to a lack of awareness on the part of physicians but also on the part of parents as illustrated by our second case and by another child not yet two years of age who vomited daily for three weeks before he was brought to medical attention. At that time, the blood lead concentration was found to be 290 mg per cent. Parental ignorance can also create the problem. Some mothers in Newark have used lead-containing plaster as pacifiers. One well-intentioned mother collected paint flakes for the child to eat "like potato chips" while watching television.

Public education can help bring the child with pica, or suspicious symptoms, to medical attention. An article on lead poisoning made one father recognize his child's pica for the danger it was. The child's blood lead was found to be 260 mg per cent. In six other families, lead intoxication was found because the parents brought their children in for review after learning that pica could lead to lead poisoning. An additional seven families had first been concerned for their own children because of a case of lead poisoning known to them.

The necessity of following children once identified as having excessive body burdens of lead is obvious. The children who were identified at any stage as requiring further investigation but who failed to obtain it are summarized in Table V. Most disturbing were the 43 cases with blood leads 60 mg per cent or higher in which there was neither a subsequent hospital admission nor another blood lead level obtained. Sometimes the failure of further investigation related to difficulties inherent in locating families. In other cases the family could not be persuaded to have additional tests made. In still others, lack of follow-up was due to inadequate communication among various interested groups. For example, the public health nurses and sanitarians, on whom the identification of the source of poisoning currently depends, did not have all names of positive ALA determinations or of all children with bloods over 60 mg per cent. Failure to follow siblings is all the more distressing in the light of the data showing that one-third of siblings[9] of children with lead poisoning may be expected to show increased body burdens of lead. These studies are supported by our own data. In siblings who were tested, almost half required treatment.

Inadequate housing has been a major obstacle to protection of families with lead-poisoned children. During or shortly after hospitalization, the home is usually visited by the Newark public health nurse and the sanitarian. The latter reports on both the condition of the paint-bearing surfaces and the per cent lead by weight in a sample paint chip. Chips of paint were tested from 64 houses in which a lead poisoned child lived. Only one-third were reported to contain over 1 per cent lead. From studies in other slum areas,[10] the rate of positives should be 50 to 70 per cent or higher. The low yield in the Newark experience may be explained by the paucity of samples submitted from each dwelling unit, in many instances only one chip.

Table V

Failure to Continue Indicated Investigation for Lead Poisoning Among Children in Newark

		%
COPR urines positive with no subsequent blood lead	99/21	43
ALA urine positive with no subsequent blood lead	33/113	31
Total blood leads with values 40 to 59 mg per cent without subsequent blood	22/169	13
Total blood leads with values 60 mg per cent or higher without treatment	43/172	25
	Total	109

Some 59 notices were served on the dwellings involved in these cases for violation of the city code. Not more than three landlords have actually been fined although code compliance was rare. In few instances was any definitive action taken during the child's hospitalization either to relocate the family or redecorate the dwelling. With half the families known to be on welfare, few could afford to repair the apartments with their own resources. Children had to be discharged, on the average, after six or seven days, the need for acute care pediatric beds making longer hospital stays impossible. Then the children returned to the environments in which they had originally been poisoned.

Newark may have the most serious lead problem in the nation: over 7 per cent of the blood concentrations were found to be 60 mg per cent and higher. Another 32 per cent of the sample had blood lead levels of 40 to 59 mg per cent. This is considerably higher than the most recent New York figures showing three-fourths of the values under 40 mg per cent, 19 per cent between 40 and 59 mg per cent, and 5 per cent 68 mg per cent and higher (Table IV). The samples may not be similar in their relevant characteristics but the gravity of Newark's problem is emphasized by the comparison.

Thus, in Newark until late 1970, screening involved too few children, the ALA test was found not to be reliable, evaluation of siblings was inadequate, and children once suspected of lead poisoning often had inadequate investigation of themselves, their siblings, and their environment. Screening by blood levels in the summer of 1970 sharpened the sense of urgency about lead poisoning in Newark.

The inadequacy of present resources as well as the inefficiency in their deployment became a community concern. It then became clear to parents, community leaders, professional workers in health and health administration, the city administration, and the medical college that the results of phases 1 (the evaluation of the 15 month preblood screening period) and 2 (the preliminary blood screening) mandated that the entire estimated at-risk population in Newark have lead determinations made in 1971. The outcome of the planned phase 3 (total screening) and 4 (remedial and preventive efforts) will be the subject of a second report in 1972.

Summary

Assessment of lead poisoning in Newark during the 15 months January 1, 1969 through March 31, 1970 showed that the number of children screened, treated, and followed were far below the number projected at risk of lead poisoning. The estimates of the severity of the problem were based on two types of screening with blood lead level determinations which showed that 7.4 per cent of the children had blood lead levels 60 mg per cent or higher, while another 32 per cent had blood leads 40 to 59 mg per cent. Community interest and resources have been mobilized by the definition of the gap between the needs of the city's children and the amount of control achieved.

Table IV.

Blood Lead Levels by Type of Screening, Summer 1970.

mg %	Newark						New York City	
	Block study		Lead Days		Total			
	N	%	N	%	N	%	N	%
less than 40	81	58.7	282	61.8	363	61.1	27,184	75.4
40-59	44	31.9	144	31.6	188	31.5	6,991	19.1
60 and over	13	9.4	30	6.6	43	7.4	1,896	5.2
Total	138	100	456	100	594	100	36,071	100

N = number

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100 Bergen Street

Radiation Safety Standards

The Food and Drug Administration has proposed that equipment manufactured for x-ray diagnosis in the healing arts incorporate new radiation control features to reduce exposure during x-ray examination. The new standard was developed by the FDA Bureau of Radiological Health. X-ray examinations, the FDA noted, constitute the largest source of man-made radiation reaching American people.

"While the beneficial applications of radiation in the healing arts are well recognized, exposures from diagnostic x-ray procedures have far more public health significance than exposures from all other man-made radiation sources," said Charles C. Edwards, M.D., Food and Drug Commissioner. "More than 90 per cent of all human exposure to man-made radiation comes from the diagnostic use of x-ray, in contrast with about one per cent from radioactive discharges from nuclear power plants about which there has been so much public concern."

One new proposal would require stationary general purpose x-ray machines to be designed to insure limitation of the beam to approximately the size of the body area to be examined. The other would require radiographic equipment to be able consistently to reproduce exposure and, therefore, image quality for given settings for voltage, current, and time.

Failure to keep the x-ray beam within the area of the body undergoing diagnostic examination is one of the commonest causes of unnecessary x-ray exposure. Reduction of as much as 50 per cent or more in the genetically significant dose from diagnostic x-ray can result from limiting the beam to approximately the size of the film or other x-ray receptor. The exposure reproducibility requirement of the standard would enable the technologist to know with confidence what results to expect at various equipment settings and thus to avoid picture retakes, a common cause of unnecessary diagnostic x-ray exposure.

X-ray equipment manufacturers would be given a year following the effective date of the standard to produce equipment complying with its provisions. The proposed standard would become effective upon republication in the *Federal Register* after 60 days for public comment.



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the 3 phases of Eve



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Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

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the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

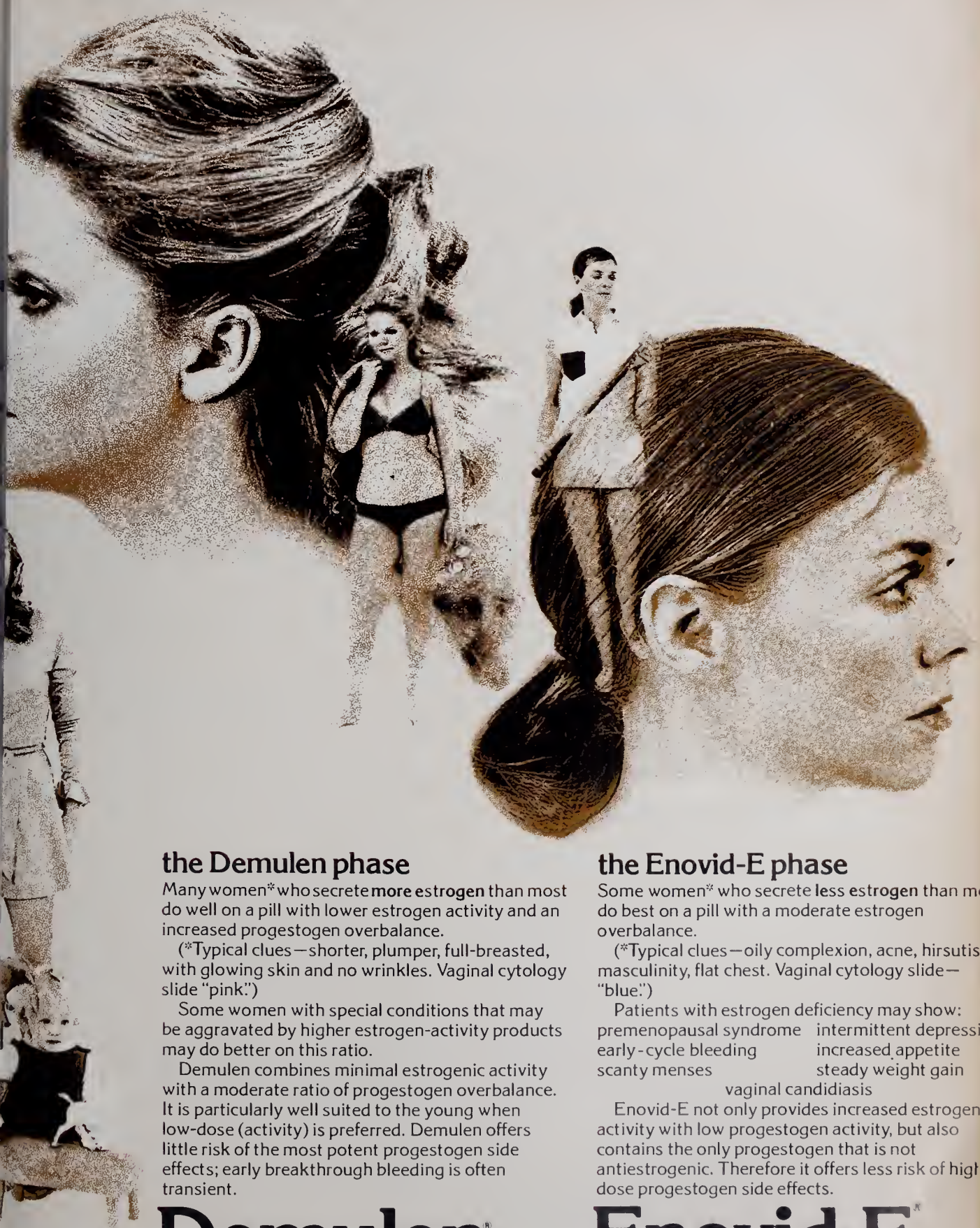
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Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing informatic
see following page.



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Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

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early-cycle bleeding	increased appetite
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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

Should all diabetics be tested for vesical function? Yes, says Dr. Weinberg and here's why.

Role of the Urologist in Diabetes Mellitus*

Sidney R. Weinberg, M.D.
Brooklyn, New York

The role of the urologist is primarily the conservation of renal function by eliminating obstructive uropathy. It must be remembered that diabetes mellitus induces or accelerates the infectious, obstructive, and degenerative diseases of the urinary tract. These lesions are:

1. Urinary tract infections, including papillary necrosis of the kidneys.

2. Kimmelstein-Wilson degenerative disease of the kidneys.[1]

3. Diabetic neuropathy with dysfunction of the bladder and, frequently, sexual impotence.

These lesions are frequently seen in combination, each one augmenting and accelerating the disease process. The problem may be non-recognition of the early lesion so that, in too many instances, extensive renal damage makes morbidity a certainty and mortality inevitable.

Urinary tract infections, including acute and chronic pyelonephritis are definitely more common in diabetics than in the general population. Robbins, Mallory, and Kinney[2] studied 307 diabetics and found a frequency of infection of more than four-and-a-half times that of non-diabetics. Others have confirmed this. Some authorities feel that there is an inherent susceptibility of the diabetic to urinary tract infections because of the increased carbohydrate content of the urine and because of specific changes in metabolism. Also, there are the specific degenerative lesions of Kimmelstein-Wilson. These intracapillary glomerulosclerotic lesions which are not amenable to treatment occur mostly in severe diabetic patients of long standing, especially those whose disease begins in childhood. Frequently overlooked is the major factor of urinary obstruction, diabetic neurogenic dysfunction of the bladder.

In contrast to the other causes of urinary tract infection, this lesion can be treated, and preferably while renal function is adequate. The examining physician must be suspicious of any urinary or genital complaints as without urologic investigation diagnosis cannot be made. The physician treating diabetic patients must be aware that symptoms are often minimal because vesical sensation is diminished, and severe changes can occur asymptomatically. It has been estimated[3, 4, 5] that at least one half of all diabetic patients have some degree of neuropathy with vesical dysfunction.

The early relationship of vesical dysfunction and diabetes was pointed out by Motzkin.[6] Three hundred and seven patients with normal blood sugar and urinalysis negative for sugar were evaluated for vesical sensation. Normal men should have a desire to void when 200 cubic centimeters of fluid are placed in the bladder. Forty-three of these patients had no sensation to void after that much fluid was instilled, and about half had an unequivocal positive glucose tolerance test. This implies that deficiency in vesical sensation may be a sign of early diabetes.

* Read before the Section on Urology, 205th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 16, 1971

Conversion from a previously normal to a diabetic glucose tolerance curve was noted later in four patients.

The diagnosis of diabetic vesical neuropathy must be thought of in the presence of the other lesions. Remember that areas of degeneration in the lumbar plexes have no uniform localization. In some patients, there may be changes in gait or in intestinal fauna. In other patients, the lesions may result in sexual impotence. In patients with neurogenic dysfunction of the bladder (with hypotonicity and enlargement) there is constant residual urine. Occasionally when the disease becomes advanced, overflow incontinence will result. An obstructive lesion of the urinary tract may be the cause of varied symptoms, such as pain and hematuria. If infection supervenes, dysuria can be the complaint. Later when the obstruction causes atrophic degeneration of both kidneys the signs are those of renal failure.

Physical examination may reveal neurologic changes, such as absent tendon reflexes and loss of sensation due to the peripheral neuritis. Determination of residual urine is simple enough, but most internists are reluctant to introduce catheters into the bladder. It is impossible for this diagnosis to be made without some instrumentation.

Nowhere in the "Case Against the Catheter" is there any dictum against the use of the catheter in the diagnosis or treatment of obstructive uropathy. The catheter is one of the most reliable of medical instruments. When used properly, it is indispensable. It is common experience for urologists to see patients, with severe pyuria and systemic reaction of long standing, being treated with urinary antiseptics, but without any test for residual urine. The excuse offered is that catheterization may lead to infection. In truth, however, the patient already has a long-standing infection that cannot improve without removing stagnant urine.

When diabetic neuropathy is suspected, diagnosis is confirmed by cystometric examination. Here a bladder capacity up to a liter is often noted. The bladder detrusor pressures are minimal so that the patient, in reality, is walking around with a big sack of urine in the lower abdomen. This is prone to be infected, hastening and augmenting the renal deterioration already begun by the arterial lesions of Kimmelstein-Wilson's disease. If the infection is severe, papillary necrosis of the kidneys may become an additional problem. In young juvenile diabetics (who are prone to degenerative diseases of the Kimmelstein-Wilson type) any lesion should be attacked vigorously.

Treatment may be with bethanechol chloride (Urecholine®) therapy or surgery. The choice depends on whether significant residual urine is present. If more than 60 cubic centimeters are present, the detrusor muscle is decompensated and surgery is probably necessary. In younger patients, partial cystostomy with Y-V plasty may be used. In older patients, a transurethral resection of the prostate gland (with or without partial resection of the bladder) should be considered. The place of partial resection in the treatment of the hypotonic bladder is controversial. However, in my experience, this procedure has successfully restored patients to proper urination. After all, the fatigued and distended detrusor muscle cannot propel a large volume of urine. If the volume in the bladder is reduced and peripheral resistance decreased, muscle efficiency is greatly enhanced.

The following histories of patients with diabetic vesical neuropathy will demonstrate the varying degrees of severity with which the disease is seen clinically.

Case One

A 56-year old male, a mild diabetic of 5 years' duration, was seen because of dysuria, frequency, occasional nocturia, and weak erections. Excretory urography showed a normal upper urinary tract. Cystoscopy revealed a residual urine of 20 cubic centimeters with a bladder capacity of 500. He had minimal hypertrophy of the prostate gland. Treatment consisted of bethanechol chloride therapy, urinary antiseptics, and multiple voiding. His urinary symptoms then improved. Bethanechol chloride was discontinued. Follow-up visits for two years have

shown no increase in residual urine and no recurrence of symptoms. He was advised to have sexual relations in the morning. It seems that both mind and body may function better then; the full bladder can also assist with erection. The patient was told that medication would not be helpful. In younger individuals with complete impotence, a surgical treatment with a prosthesis placed in both corpora cavernosa is recommended.

Case Two

A 62-year old male was a mild diabetic, so diagnosed one year ago. He had been treated by an oral hypoglycemic agent. He was seen because of irritative urinary tract symptoms. The prostate gland weighed 30 grams and was benign in consistency. Excretory urography showed normal upper urinary tracts. Cystometry (Figure 1A) showed marked hypotonicity. The patient had a transurethral resection of the prostate gland in which 15 grams of tissue were removed. The pathologist reported adenomatous and fibromuscular hyperplasia. The patient had an uneventful convalescence, but even now the patient is being treated with bethanechol as residual urine is still about 100 cubic centimeters (Figure 1B.) Careful watch is being maintained of the upper urinary tracts.

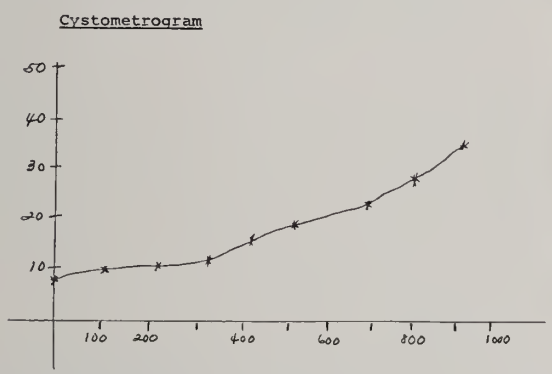


Figure 1A—Male, age 62, preoperative cystometry showing diabetic hypotonicity.

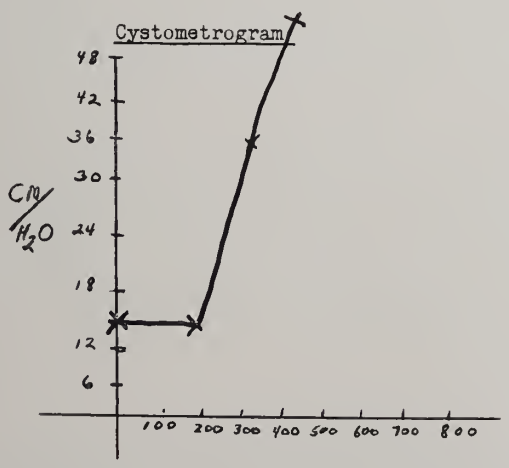


Figure 1B—Post-operative cystometry showing improvement.

Case Three

A 61-year old male patient, a mild diabetic, had had two previous transurethral resections of prostate gland and subsequent urinary incontinence for two years. Study showed a large hypotonic bladder of one litre capacity with a contracture of the vesical neck (Figure 2). Partial resection of his bladder and revision of the vesical neck with a Y-V plasty restored the patient to continence.



Figure 2—Cystogram of male, age 61, showing enlargement and hypotonicity. Note large prostatic fossa at site of previous transurethral resections (arrow).

Case Four

A male juvenile diabetic has been treated since the

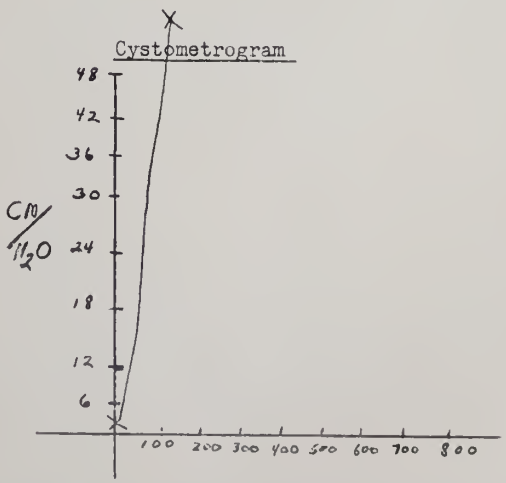


Figure 3A—Cystometry of 21-year old male showing spasm.

age of 8 with insulin. His first urologic admission was in October 1969, at age 24, for irritative urinary tract symptoms. Cystometrogram and cystometry showed cystitis and vesical spasm (Figure 3A). He was treated with urinary antiseptics and discharged improved. The patient was readmitted in February 1971. At this time the cystometry showed definite hypotonicity (Figure 3B). Because of normal upper urinary tract and lack of residual urine, the patient is being treated with bethanechol. This patient is in delicate balance and surgery probably will eventually be necessary.

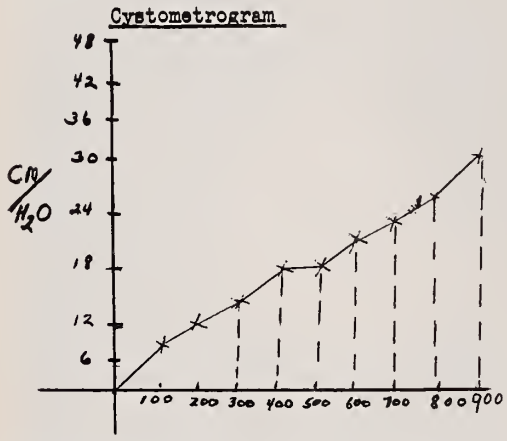


Figure 3B—Cystometry of same patient two years later demonstrating hypotonicity.

The treatment of the female patient is somewhat different. It had been standard practice to recommend transurethral resection of the vesical neck for improvement of function of the hypotonic bladder.[7] However, recent work with urethroplasty has shown that the terminal urethra may be the most obstructive area in the female urethra and that resection of the terminal urethra may be preferable. Certainly, it is a safer operation than electrosection of the bladder neck, as that procedure has resulted in urinary fistulae and incontinence in too many patients.

Case Five

A 50-year old woman was admitted in moderate renal failure with a BUN of 54.. Study showed a large bladder with over 500 cubic centimeter capacity and residual urine of 200. Urethroplasty was performed, and while it is too early for full evaluation (and the patient is still on catheter drainage) her urea is now 37 and her edema has decreased. The patient can see better and feels better than she had been for years.

Case Six

A 40-year old man was admitted for treatment of renal failure by dialysis. He was a severe diabetic taking insulin for fifteen years. He had severe eye blurring and headaches. Neurologic examination showed no gross defects. The prostate gland was only 1+ enlarged. There had always been a good urinary stream with no dysuria. Blood chemistries showed glucose of 108, creatinine 7.8, and urea nitrogen 78. These figures remained essentially the same upon repeat examinations. Here diabetic neuropathy was suspected, on the basis of probability. The bladder was drained by indwelling catheter. The patient developed a marked diuresis, putting out 4000 cubic centimeters of urine per day. Electrolyte replacement was necessary as the patient's blood sodium level decreased. After three stormy days, he improved remarkably, especially in vision. Urea nitrogen level fell to 54. Blood pressure which was initially 190/120 was reduced to 140/90. Cystometry demonstrated a bladder capacity of 1000cc with the first sensation at 300 cubic centimeters (Figure 4). Infusion excretory urography visualized two moderate-sized kidneys with a nephrogram effect. After three weeks of catheter drainage, a transurethral resection of the prostate gland was done. Fifteen grams of benign tissue were removed. Post-operative course was uneventful and he was discharged from the hospital one week later without requiring any dialysis.

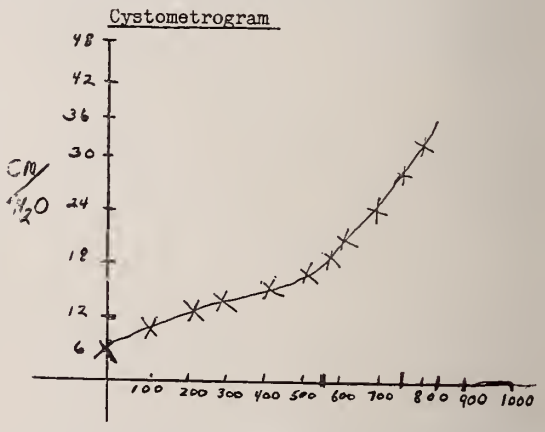


Figure 4—Cystometry of 40-year old male, showing marked hypotonicity without any urinary tract symptoms.

This last patient's case history emphasizes the difficulties involved in the diagnosis of diabetic neuropathy. Although the disorder was advanced to a terminal state, he was never examined for urinary obstruction, probably because all urine cultures showed no growth and he maintained a good urinary stream.

Summary

It is recommended that all diabetic patients be tested for vesical function. Young males with complete sexual impotence should be advised about surgical implantation of a prosthesis. Females with hypotonicity should be treated by urethroplasty before trans-

urethral resection of the vesical neck is done. Partial resection of the bladder should be considered in the treatment of patients incontinent of urine and with large bladders.

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555 Prospect Place

Sex Hormone Levels and Aggressive, Dominant Behavior

The relationship between male sex hormones and aggression will be studied under a $62,-283 research grant announced by HEW's National Institute of Mental Health, Health Services, and Mental Health Administration. The questions being investigated include: Do increased levels of sex hormones in males lead to more aggressive behavior and higher social rank? Are hormones responsible for the aggressive surge to the top or do increased hormone levels reflect social rank and aggressive activity? To be reviewed will be the relationship between testosterone and aggression in rhesus monkeys.

The research will be conducted by Dr. Robert M. Rose, Boston University School of Medicine, and Dr. Irwin Bernstein, Yerkes Regional Primate Research Center. These scientists have already shown in the animals that testosterone is correlated with aggression. A clear cause-and-effect relationship, however, has not been proved.

In the new study, they hope to learn whether increased testosterone leads to greater aggression and, thus, to higher social rank or whether the hormone levels reflect social rank and dominance. It is possible that testosterone may be inhibited in subordinate animals by the stress of living in a social group. This diminished level of testosterone could, in turn, result in decreased aggressive behavior appropriate for a low-ranking male.

Dr. Rose has found that soldiers under the increased stress of combat training usually had lower testosterone levels than did soldiers who were attending Officers Candidates School.

In studies of prisoners at the Patuxent (Maryland) Institution for Defective Delinquents, the researcher found that inmates arrested before the age of 18 for violent or aggressive crimes secrete more testosterone than other prisoners. However, he found no differences in the testosterone levels of prisoners who were well-behaved or those who were aggressive.

The investigators will observe the animals' hormone production in a variety of situations. These will include behavioral changes associated with rising testosterone levels during puberty, seasonal changes in testosterone levels, and the hormonal response to exposure to sexually responsive females.

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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria ganorrhaeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. ganorrhaeae* between Trobicin and penicillin.

Indications: Acute ganorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhaeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrheo may mask o delay the symptoms of incubating syphilis. Potients should b carefully examined and monthly serological follow-up for c least 3 months should be instituted if the diagnosis of syphilis i suspected.

Safety for use in infants, children and pregnant women has nc been established.

Precautions: The usual precautions should be observed wit atopic individuals. Clinical effectiveness should be monitored t detect evidence of development of resistance of *N. gonorrhoeae*

Adverse reactions: The following reactions were observe during the single-dose clinical trials: soreness at the injection site urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in norm human volunteers, the following were noted: a decreose in hemo

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Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

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Active against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. ganorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

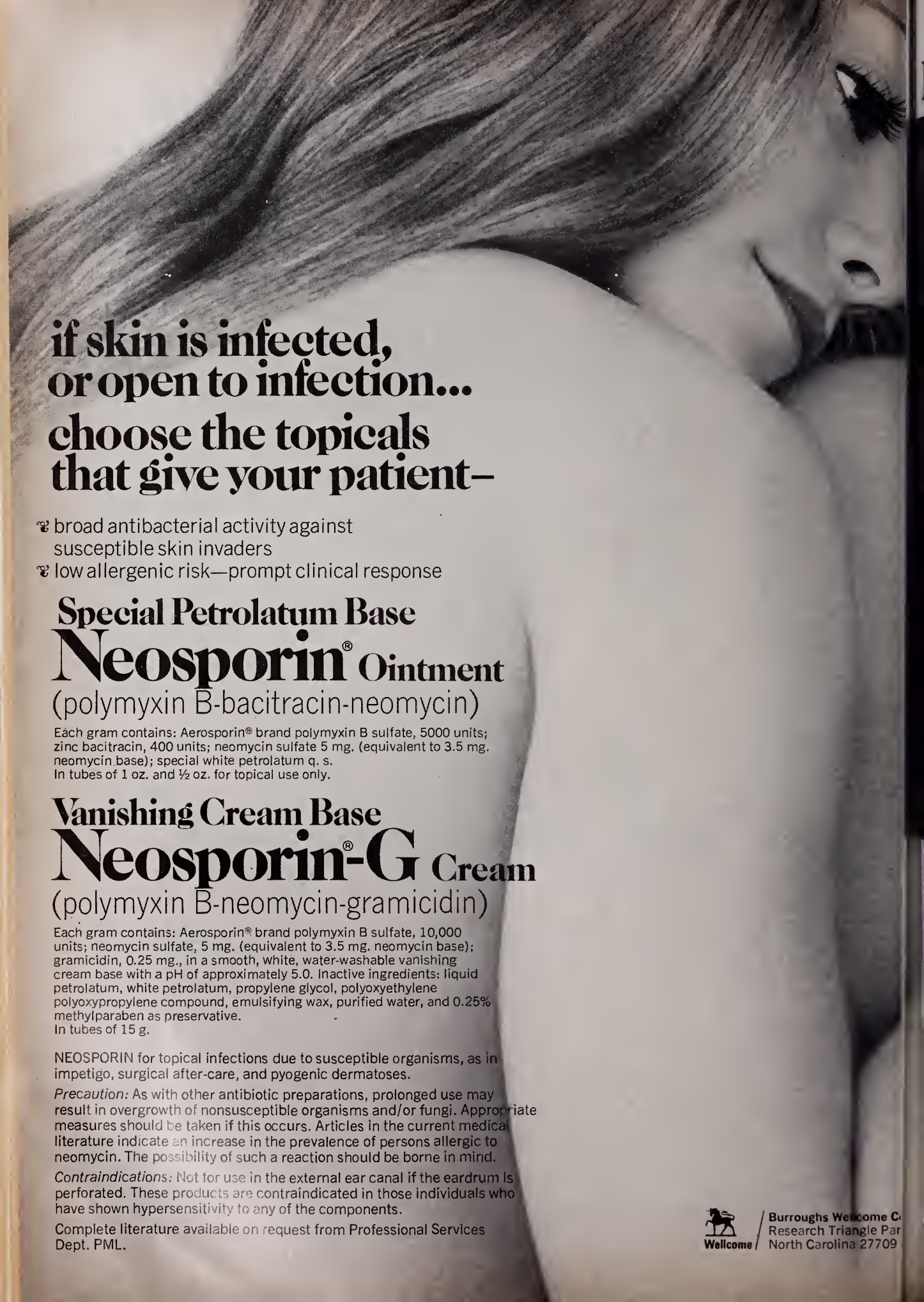
globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normol volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C ond use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areos where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with o concentration of spectinomycin dihydrochloride pentahydrate equivolent to 400 mg spectinomycin per ml. For intramuscular use only.
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Human pharmacology: Rapidly absorbed ofter intramuscular injection. A two-gram injection produces peak serum concentrations averaging obout 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averoging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
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In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

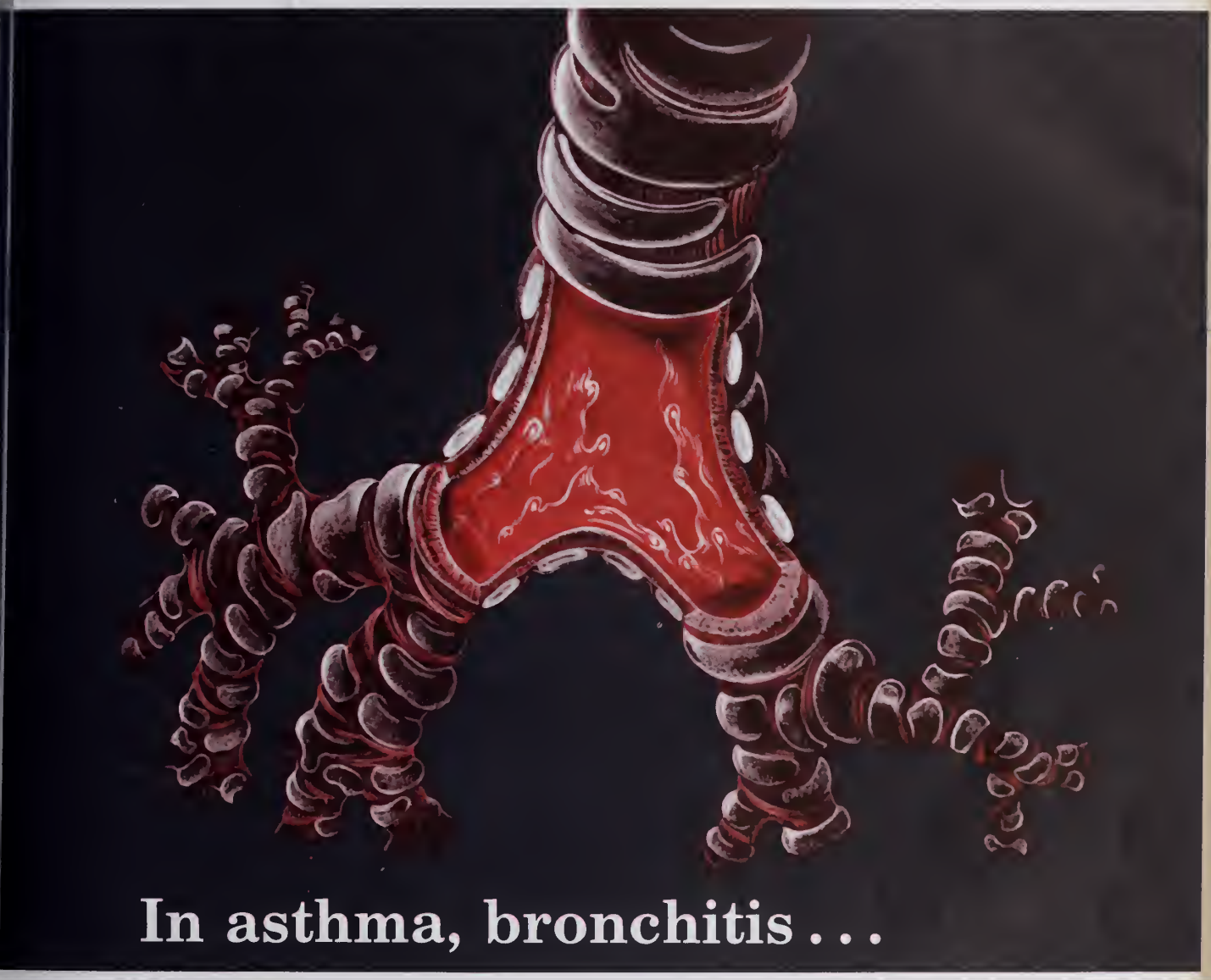
Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

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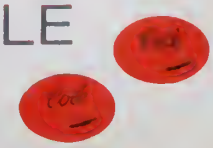
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THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIDSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIOE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

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References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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Triglyceride, lipoprotein, and cholesterol determinations will be helpful in evaluating likelihood of atherosclerosis.

Lipid and Lipoprotein Screening Tests*

Who, Why, When, How?

Marvin Shuster, M.D., Gonzalo Ramirez, M.D., and Hugo C. Pribor, M.D./Perth Amboy

Can atherosclerosis be reduced or prevented? After all, cardiovascular diseases account for a larger portion of deaths in the U.S.A. than any other cause. Coronary atherosclerosis is now appearing at earlier ages than in the past. Autopsies on young soldiers in the Indo-China[1] war show a greater incidence of arteriosclerosis than was seen in soldiers in the Korean conflict less than twenty years ago. In our own autopsy experience, we have seen men in their twenties with marked coronary arteriosclerosis. Some also show evidence of healed myocardial infarction. An estimated one of every 200 babies has a Type II hyperlipidemia which can lead to premature arteriosclerosis.[2]

On the positive side, we now have better tools for diagnosing, possibly preventing, and managing coronary and generalized atherosclerosis. Principal among the improved diagnostic tools are the triglycerides determination, lipoprotein electrophoresis, and phenotyping. Better diet management, with or without drug therapy, has proved effective in managing and treating the conditions.

Factors Increase Risk of Atherosclerosis

Several factors appear to predispose an individual to develop atherosclerosis and particularly coronary atherosclerosis and coronary heart disease. These include hypercholesterolemia, obesity, hypertension, cigarette smoking, physical inactivity, and, possibly, genetic factors.[3] Thus, the first logical step in coping with atherosclerosis is to find patients who have a predisposition to develop the disease or who already have some indication of existing disease. The combination of a cholesterol determination and the triglycerides determination is an effective screening test for cardiovascular disorders either in the manifest or the incipient state.

Connor[4] recently reviewed the relationship of hypercholesterolemia to coronary heart disease. Here is a summary of his findings:

1. Occlusive atherosclerosis follows elevated blood cholesterol.

2. Although cholesterol is both produced and absorbed from dietary sources, the dietary component is additive.

3. Cholesterol cannot be degraded by the body; it remains in the blood or tissues until excreted.

4. Age-matched human populations with little heart disease have low plasma cholesterol.

5. Plasma cholesterol levels can be lowered therapeutically to levels associated with less coronary heart disease and atherosclerosis.

6. Experimental work in monkeys indicates that lowering blood cholesterol levels can improve existing coronary atherosclerosis.

Connor's studies[4] have led him to believe that cholesterol levels above 220 milligrams per cent and triglycerides concentrations

*From the Laboratories of Perth Amboy General Hospital, Perth Amboy, New Jersey

above 150 should be considered elevated and that treatment should then be instituted. The Framingham (Massachusetts) prospective study[5] shows the incidence of coronary heart disease attacks to be five times greater in men with cholesterol above 265 milligrams per cent compared with those whose cholesterol was 220 or less in the age group between 35 and 44.

No Single Test

Although it is the most familiar of the lipid substances, the most abundant and easy to assay, cholesterol quantitation is only one tool we have for assessing disorders of lipid metabolism. Alone it is not enough. It may miss Type IV lipoprotein phenotype since cholesterol is often normal in these patients. Nor is the triglycerides determination enough by itself; it could miss Type II phenotype abnormalities for similar reason. Both tests together, however, do comprise an adequate screen.[6, 7]

A recent study in our laboratory indicates this. We did cholesterol and triglycerides tests on 500 random fasting adult medical admissions. Lipoprotein electrophoresis tests were performed on the 198 cases where cholesterol and/or triglycerides were elevated. Table I summarizes these results. It shows that, of the 500 cases, 97 had abnormal cholesterol levels, 143 had triglycerides abnormalities, and 109 had lipoprotein abnormalities. Of the 109 lipoprotein abnormalities, 41 would not have been investigated if cholesterol abnormalities only were used to screen patients and 26 would have gone undetected if triglycerides abnormalities only were considered. All, however, were found by doing the two tests as a basic screen. A practical delineation of these disorders makes quantitation of triglycerides and cholesterol and lipoprotein electrophoresis mandatory to establish the phenotype to which these patients belong.

TABLE I

Abnormalities in Atherosclerosis-Related Tests on Random Adult Medical Admissions

Patients Tested	500
Cholesterol abnormalities with normal triglycerides	55
Triglycerides abnormalities with normal cholesterol	101
Both cholesterol and triglycerides abnormalities	42
Lipoprotein electrophoresis abnormalities total	109
among patients having both abnormal cholesterol and triglycerides	42
among patients having normal cholesterol, abnormal triglycerides	41
among patients having normal triglycerides abnormal cholesterol	26
Classification of lipoprotein electrophoresis abnormalities	
Type I	1
Type II	50
Type IV	58

The determination of total lipids as a screening test has been abandoned and properly so since an increased value does not pinpoint which single fraction or combination of fractions is contributing to this elevation. Estimation of the phospholipids has shown little clinical usefulness and is seldom performed.

Composition of the Lipid Fractions

Many different substances in the serum comprise the lipid fraction. These include cholesterol, triglycerides, free fatty acids, cephalothin, phospholipids, esterified fatty acids, cerebrosides, lipoprotein, and carotenoids. Normally, plasma contains between 400 and 1000 milligrams per cent of lipid substances.

Lipids are insoluble in water and have a nonpolar configuration. They can be solubilized in the plasma by being bound to plasma proteins. Most lipids are bound to the alpha-2 and beta globulins, forming complexes known as lipoproteins. Since the lipoproteins have electrical polarity and vary in size and configuration, they can be separated by their differential migration in an electrical field by electrophoresis.

The free fatty acid component (a metabolically active fraction with high rate of turnover) is used as fuel by the body. It is known at this time, however, that quantitation of the free fatty acids, phospholipids and lipids other than cholesterol and triglycerides have little or no clinical significance. The triglycerides in serum are present either as micro-

scopic droplets called chylomicrons or as complexes with one of the proteins acting as a carrier. An elevated triglycerides level in the fasting individual is an excellent indicator of hyperlipidemia—be it associated with obesity, liver disease, thyroid disorders, or diabetes. Triglycerides also are elevated in inherited defects of lipid metabolism.

The serum triglycerides test appears to fulfill, better than other lipid determinations, the criteria for a diagnostic test in coronary artery disease. It is also useful in establishing the type of hyperlipidemia displayed by a patient and in following the effects of therapy.

In 1967, Frederickson, Levy, and Lees[8] presented their landmark paper defining the hyperlipemic states into five groups or phenotypes. A conclusive diagnosis of hyperlipidemia can be established by doing a cholesterol and triglycerides test after a ten-hour fast following a normal dietary regimen for at least ten days prior to testing. If under these conditions both triglycerides and cholesterol are normal, it is safe to say that the patient does *not* have hyperlipidemia, with a degree of confidence that is quite adequate for current use. A more precise delineation of phenotype can be made after lipoprotein electrophoresis. Table II presents the major findings in the five different hyperlipoproteinemia phenotypes.

Some infants born with a genetically determined defect of lipid metabolism, associated with severe and/or premature arteriosclerosis in later life, can be identified at birth.[9] It is hoped that treatment in infancy and childhood may prevent or delay atherosclerosis resulting from the Type II hyperlipidemia. The umbilical cord blood in these infants often shows increased cholesterol. This disorder is 100 times as frequent as phenylketonuria, a disorder of metabolism for which many states have an obligatory screening program and which is estimated to occur in about 1 in 20,000 births.

Managing and Treating Hyperlipidemia

Guidelines for treatment on a dietary and drug basis have been put forth by numerous investigators[10, 11]. The benefits derived from the early detection of hyperlipemic disorders cannot yet be evaluated accurately. Only through early diagnosis can effective treatment be given and screening programs for these disorders will prove important. Many interested scientists in the 1960's investigated the role of diet in the evolution of hyperlipidemia and the subsequent formation of atherosclerosis. The interrelationship of carbohydrate metabolism, hyperlipemia, and atherosclerosis is also being clarified.

Kuo[12] has proposed that there are "fat induced" and "carbohydrate induced" hyperlipidemias. It has been demonstrated that Type I and II phenotypes require a low-fat diet to control hyperlipidemia, while Types III and

TABLE II
Classification of primary hyperlipidemia*

Type	Lipoprotein	Triglycerides	Cholesterol	Carbohydrate Sensitive	Fat Sensitive
I (rare)	Chylomicra elevated	Elevated	Normal	No	Yes
II	Beta Lipoproteins elevated	Normal	Elevated	No	Yes
III	Abnormal Beta lipoproteins present	Elevated	Elevated or Normal	Yes	Yes
IV	Pre-Beta lipoproteins elevated	Elevated	Elevated	Yes	No
V	Chylomicra and pre-beta lipoproteins elevated	Elevated	Elevated	Yes	Yes

*Adapted from Fredrickson's 5 Major Categories of Primary Hyperlipidemia.

IV are indications for carbohydrate restriction. The Type V phenotype appears to be a combination of Types I and V, possessing features of both. Dietary management of these patients requires a balanced low-calorie diet high in unsaturated fats.

Therapy of the lipoprotein disorders is frequently a combination of dietary management and drug therapy. Type I patients generally must be managed by diet therapy consisting of diet sufficiently low in fat to prevent recurring bouts of pain but high enough to maintain an adequate intake of fat-soluble vitamins. None of the antilipemic drugs currently available can maintain a normal triglycerides level in the blood.

In the Type II patient, we must determine whether he represents a secondary (acquired) or a primary genetic hyperbetalipoproteinemia. Obviously if it is secondary to some other disease, treatment aimed at the primary initiating disease is indicated. In the familial variety, cholesterol must be severely restricted and unsaturated fats can be added to the diet. Some drugs used with varying degrees of success in these patients have been cholestyramine, beta-sitosterol, D-thyroxine, clofibrate and estrogens.

Patients with the Type III or broad beta-lipoproteinemia should be accurately identified, since therapy of specific nature can benefit them greatly. Blood lipids in these individuals can be brought to normal by a combination of diet and drug therapy, and secondary manifestations, such as xanthomata, can be markedly improved. Diet should be low in cholesterol and clofibrate can bring about a 50 per cent reduction in cholesterol and up to 80 per cent reduction in triglycerides.

In the Type IV individual, weight reduction effects a reduction of hyperlipemia. Frequently, when desired weight has been achieved, blood lipid studies are found to be normal. Since this is a carbohydrate-sensitive disorder. dietary management also includes an increase in polyunsaturated fats at the expense of dietary carbohydrates. Clofibrate and nicotinic acid have also been used with varying degrees of success.

The Type V appears to represent a combination of Type I and IV. It is treated in a manner similar to both. Abdominal pain can be controlled by diet low in fat and carbohydrate and clofibrate may help some of these patients by further lowering their plasma triglycerides.

How, and Whom, to Screen?

A significant number of infants display, in their umbilical cord blood, a Type II lipoprotein phenotype pattern. Because of this, we suggest screening all newborn infants by a cholesterol determination to be followed up by a triglycerides and lipoprotein electrophoresis study when the cholesterol is elevated.

In adults, both cholesterol and triglycerides determinations should be made. Where elevations of *either* fraction are noted, lipoprotein electrophoresis should be done. Patients over the age of twenty should be screened in this manner at the time of routine physical examination. Inclusion of these tests in a routine admissions battery for hospitalized patients would also be of obvious benefit to such patients. Whenever a patient is found to have a familial type of hyperlipidemia, all members of his family should also be investigated since other cases will probably be discovered.

The test may also be done as a part of an ambulatory periodic health screening examination as performed by many industries. Other indications for lipid screening tests are in patients with diseases frequently associated with abnormalities of the blood lipids. These include diabetes mellitus, thyroid dysfunction and chronic hepatic diseases among others.

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Something New in Reproduction

A new test for predicting ovulation some days in advance has been devised by Raymond Foster and William Busse of Weston Laboratories. This simple, inexpensive saliva test promises to make the "rhythm method" really work at last. A woman simply places a strip of treated paper in her mouth for a few minutes each day. When it turns blue, she must abstain from sexual relations for five to seven days.

The "rhythm method" of sexual continence during fertile periods is the only birth-control method approved by the Roman Catholic Church, and as such is the only means of birth control fully acceptable to millions. Previous difficulty with tests to identify a woman's fertile period was that by the time positive physical signs appeared, ovulation had already taken place. The test will not be available for widespread use until completion of further studies and approval by the U.S. Food and Drug Administration.

A major step toward the reproduction of mammals outside the body was made by Dr. Yu-Chih Hsu of the Johns Hopkins University School of Hygiene and Public Health. Dr. Hsu grew fertilized mouse eggs in the laboratory to the heart beating stage. This could lead to a better understanding of the critical stages of human development before birth.

Several new contraceptive drugs are in the development stage. The "mini-pill" would prevent conception by stopping the sperm from entering the uterus. It is already on the market in some countries and will most likely be available in the U.S. within the year. Another method, that of an implantable, sustained-release preparation, probably won't be ready for large-scale trials for two years. The "morning-after pill," of the synthetic estrogen, diethylstilbestrol (DES) is not ideal for routine use. The drug has been accused of precipitating malignancies and nausea is a frequent side effect. Progress is also being made on making sterilization reversible for both men and women.

The storage of sperm for future use has become a commercial reality. Nearly 70 women have had babies by means of artificial insemination with thawed, deep-frozen semen. A number of husbands have had semen samples frozen and stored before undergoing sterilization.

Although no new liberal state abortion laws have been passed this year, New York's new law has had strong impact. Both maternal and infant mortality has dropped since the law went into effect, and the number of illegitimate births decreased for the first time in a decade.



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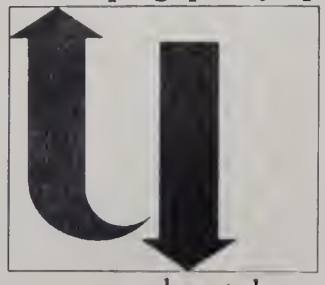


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Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

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Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

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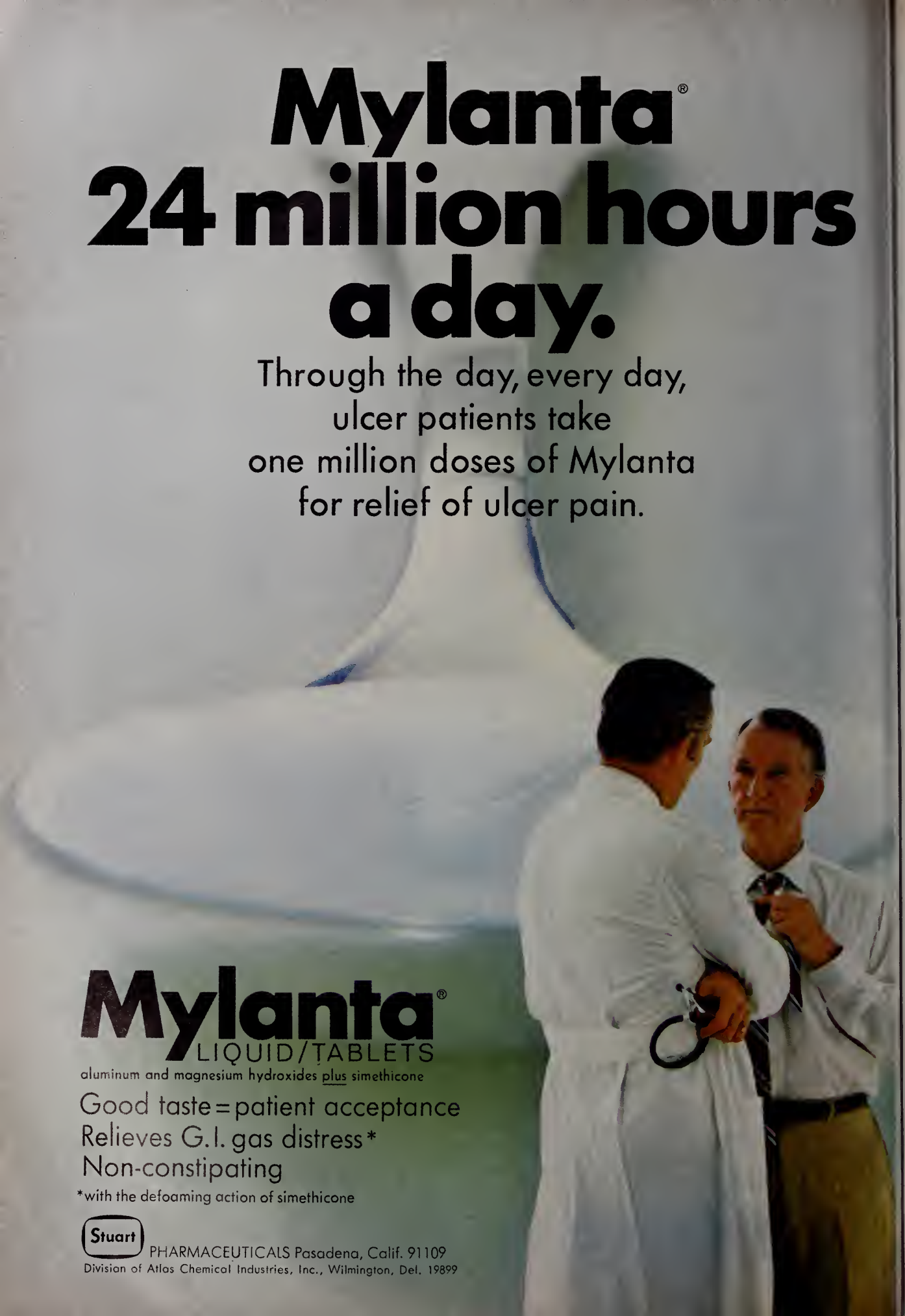
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Hypercalcemic Crisis in Hyperparathyroidism*

Report of a Case

Edward M. Miller, M.D., et al./Englewood

Hypercalcemic crisis secondary to an acutely hyperfunctioning parathyroid adenoma is a life-threatening surgical emergency. It merits prompt recognition and swift treatment. We are reporting a recently treated case.

A 43-year old nurse was admitted to the Englewood Hospital on August 17, 1970, because of severe epigastric pain, nausea, vomiting, and obstinate constipation. She had had total abdominal hysterectomy three weeks previously because of metrorrhagia and suprapubic pain of three months' duration. A uterus containing multiple leiomyomas was removed. During the immediate postoperative period, she complained of some dysuria, nausea, moderate epigastric pain, as well as generalized muscle aches and left lumbosacral pains. Following her hospital discharge on August 4, 1970, epigastric distress and constipation progressed, along with generalized weakness, visual blurring, and a severe unilateral headache. When readmitted she was drowsy, dehydrated, and lethargic. Blood pressure was 120/80, pulse was 64, and the temperature 98.2. Examinations of the fundi, neck, heart, and lungs were within normal limits. The abdomen was distended, there was mid-epigastric tenderness, and bowel sounds were hypoactive. Laboratory examinations were as follows:

Hemoglobin 12.4 Gm; hematocrit 36.8 per cent; leukocytes 11,000 (normal differential); serum sodium 129; potassium 2.9; chloride 105; carbon dioxide 29; pH 7.41; pCo_2 45. A serum biochemical profile (SMA 12/60) revealed: Calcium 16 mg; inorganic phosphorus 2; uric acid 8; cholesterol 210; total bilirubin 0.3; SGOT 25 units; LDH 120 units; alkaline phosphatase 105 units. Electrocardiogram was normal.

Roentgenograms of the abdomen suggested paralytic ileus. There was diffuse calcification of the upper pole of the left kidney. Roentgenograms of the chest, clavicle, and hands were within normal limits.

On the day following admission, the patient was more lethargic. Abdominal pain and distention had increased, and a nasogastric tube was passed. Intravenous therapy with potassium supplements was instituted. A repeated serum calcium was 16.4 milligrams.

The third day after readmission, she had persistent abdominal pain; the serum amylase was 300 units, and the lipase 24. Because of her clinical deterioration, she was seen in surgical consultation by one of us (E.M.M.). On examination of the neck, a 2 centimeter, firm, elliptical mass was found in the left paratracheal area. At this time, serum calcium was 18 and the phosphorus was one milligram.

The patient was promptly brought to the

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* Coauthors are Henry M. Glover, M.D. and Luis Nunez, M.D. This work is from the Englewood Hospital where Dr. Miller is Attending Surgeon, Dr. Glover is Attending Pathologist, and Dr. Nunez is Resident in Surgery.

operating room in a semi-stuporous state. Under general anesthesia, the thyroid area was explored through a standard collar incision. There was an elliptical tumor, 4 by 2 centimeters in size, just inferior to the lower pole of the left lobe of the thyroid. The tumor was yellowish-pink in color, with a smooth surface. It was not adherent to the surrounding tissue. There were no suspicious lymph nodes. Meticulous examination of the thyroid and paratracheal areas revealed no additional tumors. Three parathyroid glands were identified. The tumor was carefully dissected away from the surrounding tissue with minimal manipulation. A vascular pedicle extending from the inferior left pole of the thyroid to the tumor was ligated and transected, and the mass was extirpated.

Pathological Examination: (by Dr. Henry Glover) Specimen consists of a circumscribed, soft, pale, tan mass weighing 8 Grams. Sections through the mass reveal a homogeneous, soft, pale, tan cut surface, with a central irregular zone of translucent degenerative appearance (see Figure 1).



Figure 1—Parathyroid adenoma. Sectioned surface showing central degeneration.

Histologic: Sections demonstrate an encapsulated, highly vascular, densely cellular tumor mass comprised predominantly of rather uniform (although irregularly enlarged) chief cells of parathyroid type (see Figure 2). The cells are arranged in irregular cords and clusters, with focal formation of small acini, which in some instances contain eosinophilic secretion (see Figure 3). Cell cytoplasm shows irregular prominent vacuolization, and the nuclei are fairly uniform, small, round, and finely granular. No mitotic activity is seen. The central portion of the mass shows prominent stromal edema separating cell cords and clusters (see Figure 4). Uninvolved normal, parathyroid tissue is seen within the soft tissue extrinsic to the tumor; this parathyroid tissue is comprised of somewhat smaller, but otherwise similar cells and contains a moderate amount of adipose stroma.

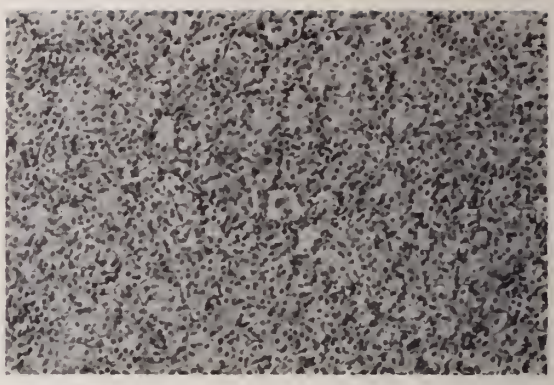


Figure 2—Peripheral tumor showing characteristic histologic pattern of parathyroid adenoma consisting of irregular compact tumor cell cords and clusters, and some true acini lined by vacuolated cells.

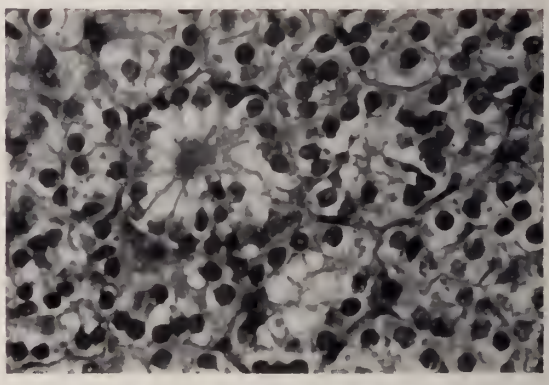


Figure 3—High power view of peripheral tumor showing uniform small benign-appearing nuclei, absence of mitoses, and abundant focally vacuolated cytoplasma of chief cells arranged in distinct clusters—note acinar formation.

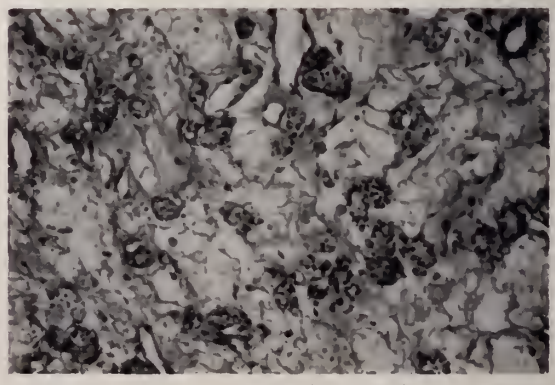


Figure 4—Central degenerative portion of tumor showing isolated residual tumor cell clusters in edematous stroma.

Postoperatively, attention was directed to the pancreatitis, instituting continuous nasogastric suction, probanthine, and parenteral fluids and electrolytes. On the first postoperative day, she felt weak, but was more alert. Serum calcium had dropped to 12.5 milliliters, the amylase to 240 units, and the lipase to 12.5 units. On the second day, there was marked subjective and objective improvement. Calcium was 9.2, phosphorus 1.9, and the lipase 3 units. On the following day, she complained of diffuse headache and cramps in both thighs. Chvostek's sign was positive bilaterally. Serum calcium now was 8.1 and the phosphorus 1.8. Calcium gluconate was administered intravenously every eight hours and Vitamin D (50,000 units) was given twice a day. During the next few days, the serum calcium dropped to a low of 7.8, and Chvostek's sign continued positive. Clinically, the patient was markedly improved, alert, with no abdominal discomfort. She was discharged two weeks after admission on a regimen of oral calcium lactate and Vitamin D Supplementation. At the time of follow-up (two months after surgery) she was asymptomatic, working full-time, with no symptoms of pancreatic insufficiency. The serum calcium and phosphorus were then normal.

Acute hyperparathyroidism or parathyroid crisis presents symptoms secondary to calcium intoxication. The precipitating factor in acute hypercalcemia may be systemic infection, surgery, anesthesia, excessive palpation of the neck, hemorrhage in an adenoma, prolonged bed rest, or dehydration.[4, 9, 11, 12, 18, 26] Any process which accelerates the liberation of parathormone, decreases renal function, or mobilizes bone calcium may produce a sudden elevation of serum calcium. Symptoms of involvement of the central nervous system are almost invariably present: lassitude, irritability, confusion, memory loss, decreased mental acuity, somnolence, stupor, or coma. There may be gastrointestinal symptoms such as anorexia, vomiting, constipation, and abdominal pain. Urinary symptoms such as polyuria resulting in dehydration are common. Neuromuscular involvement may cause backache, weakness, paresthesias, and peripheral neuralgia. The electrocardiogram may show shortening of the QT interval and virtually absent ST segments. In contrast to chronic hyperparathyroidism (in which a palpable tumor is rare), about 40 per cent of patients with hypercalcemic crisis present with a palpable cervical mass.[26] Markedly elevated serum calcium levels occur in every case, values above 15 milligrams being the rule. Serum phosphorus levels are usually low, but may be normal or high depending on the presence of renal insufficiency. Hypokalemia is frequent, resulting from the action of parathormone on the renal tubules, as well as from vomiting. Hypercalcemia may act on the myocardium to produce cardiac arrhythmias[16] from atrial flutter to heart block. Acute pancreatitis may accompany hyperparathyroidism. When severe pancreatitis is accompanied by an *elevated* serum calcium, the physician should think of an associated hyperfunctioning parathyroid adenoma. Careful clinical and roentgenologic examination will rule out other causes of hypercalcemia such as hypervitaminosis D, milk-alkali ingestion syndrome, multiple myeloma, and osseous metastatic disease.

Toxic hyperparathyroidism with rising serum calcium levels, elevated urea nitrogen, and decreasing urinary output will be lethal without operative intervention. The latter signs, together with clinical deterioration of the patient constitute absolute indications for immediate exploratory surgery.[9, 28] Since 1923, when Dawson and Struthers[5] first reported a case of fatal acute hyperparathyroidism, there have been about 100 published cases. There has been 100 per cent mortality in patients with acute hyperparathyroidism who did not undergo surgery.[18] The surgical mortality rate has been 17 per cent, the deaths occurring in those who were moribund at the time of operation or in those in whom there was an undiagnosed additional adenoma.

Lemann and Donnatelli[17] have reviewed the medical methods of attempting to decrease serum calcium. Measures designed to remove

or bind serum calcium meet with little success due to the huge stores of skeletal calcium. Administration of sodium sulfate, sodium phosphate, sodium chlorhydrate, hemodialysis, and peritoneal dialysis have all been tried,[3] with generally poor results.[9] Recent reports have demonstrated that administration of calcitonin causes rapid inhibition of bone resorption.[8, 10, 14, 19, 20, 21, 23, 25, 27] Since the announcement of the synthesis of the human form of calcitonin, it may be possible to administer this material and temporarily arrest the process, allowing time for better preparation and averting urgent surgery in a moribund patient. Until the preparation of calcitonin is available commercially, emergency surgery will be required.

Surgical exploration for parathyroid adenomas has been well described in the surgical literature. It is imperative to exclude the presence of multiple adenomas for if one is retained in the presence of hypercalcemic crisis, death will ensue in the majority of cases.

Removal of the adenomatous tissue usually results in clinical improvement within a few hours, although it may be 48 hours before a significant drop in the serum calcium is noted. During the first few postoperative days, periodic examination of the patient for signs of tetany along with serial calcium determinations will point out the frequent need for supplementary intravenous calcium gluconate, followed by oral calcium lactate and Vitamin D. Postoperative shift of magnesium to the intercellular compartment can result in a drastic drop in serum magnesium and its attendant severe neurological symptoms. Intravenous magnesium sulfate is administered as needed.

Summary

A patient with hypercalcemic crisis secondary to a parathyroid adenoma together with acute pancreatitis has been presented. Emergency exploration of the neck with extirpation of a large parathyroid adenoma was performed. Convalescence was essentially uneventful. More frequent use of routine serum biochemical profiling may expose more cases of undiagnosed hyperparathyroidism, possibly averting life-threatening acute hypercalcemic crisis.[7]

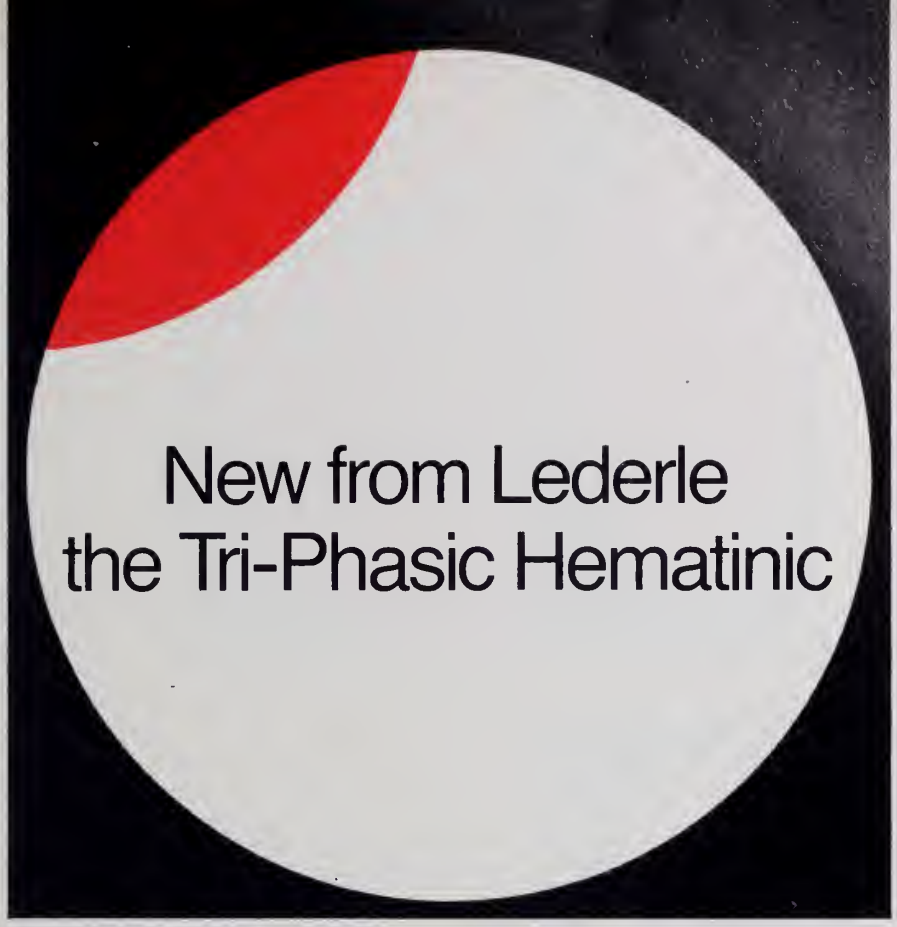
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The National Center for Health Services Research and Development of the Department of Health, Education, and Welfare has recently awarded the Department of Industrial Engineering at the University of Missouri a training grant to support a Ph.D. program in health care systems design. A vital feature of the program is the unique collaboration between the University School of Medicine and the College of Engineering. The program emphasizes industrial engineering analysis tools, as well as medical diagnosis and treatment practice, health care organization, and methods of health care systems evaluation. These areas of emphasis are applied in a series of design experiences. The program culminates in an original research dissertation.

A limited number of openings for admission and financial support are available to qualified persons with medical, paramedical, engineering, and science backgrounds, and who have a professional commitment to research, design, or management of health care systems. Persons with a strong quantitative background who are interested in the program may write for more information to H. Allan Knappenberger Ph.D., Department of Industrial Engineering, University of Missouri, Columbia, Missouri 65201.



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The pharmacologic theory of affective disorders seems to be supported by this experimental study.

Mood Changes During L-Dopa Therapy

Amechi Anumonye, M.D./Newark*

The bipolar concept in catecholamine studies views depression and mania as related but opposite states; according to this concept, depression is associated with *decreased* and mania with *increased* functional norepinephrine at central adrenergic nerve endings.

Indirect evidence supporting the theory linking brain serotonin to mood disorder include: (a) depressive symptoms result from the lowering of functional brain norepinephrine by reserpine; (b) the diminution of cerebral dopamine by alpha-methyl-dopa leads to depressive illness; and (c) monoamine oxidase inhibitors and tricyclic amines, both anti-depressant agents, raise functional brain norepinephrine.[4] Direct evidence supporting the brain-serotonin theory of depression includes the transitory euphoric state associated with intravenous administration of L-Dopa. Oral L-Dopa at high dosage has been reported in one patient to reverse a depressive illness.[5] While evidence does support the effectiveness of L-Dopa in Parkinson's disease, the reported side effects of large dosages include psychic manifestations as hallucinations, delusion, nocturnal illusions, and vivid dreaming, as well as a feeling of well-being and relaxation.[5, 6, 7] Some workers have observed, with high dosages of L-Dopa injection, hyperactivity consistent with an euphoric state.[8]

In this study we have re-examined the temporal relationship of mood changes to oral L-Dopa therapy in Parkinson's disease, and evaluated the hypothesis relating the action of L-Dopa on brain norepinephrine and the affective disorders.

Three patients with Parkinson's disease were investigated for periods ranging from 71 to 111 days in the Hoffmann-La Roche Special Treatment Unit of Martland Hospital in Newark for L-Dopa metabolic studies. The regime included: (a) the physician's interview; (b) recognized structured interview schedules; and (c) the analysis of case records. In addition, (d) the Minnesota Multiphasic Personality Inventory (MMPI) was administered on admission and again to patients 1 and 3 when the Parkinson's symptoms had been adequately controlled. This information was processed by computers, courtesy of the Roche Psychiatric Service Institute.[9] Behavioral data were collected twice daily (principally by the nursing staff) using the mood rating method suggested by Bunney, *et al.*,[10] and applying manic and depressive scales similar to those of Schwartz, *et al.*[11]

Meticulous controls of the drug trials were maintained by the Hoffmann-LaRoche Research Team. For 30 days before the L-Dopa was administered, patient Number Two received trihexyphenidyl (Lederle's brand, tradenamed Artane®). All patients were given placebos for a week or more before we started the L-Dopa.

Results

Table 1 shows characteristics of the patients

* The author, now a faculty member of the College of Medicine of the University of Lagos in Nigeria, was Director of Psychiatry at the Martland Hospital Unit of the CMDNJ.

on admission and at time of satisfactory clinical improvement in Parkinson's disease.

Table 2 shows the temporal relationship of the dosages of L-Dopa to the mood ratings and to the symptoms of Parkinson's disease. Change in mood rating does not correspond strictly to the improvement in physical symptoms.

there overt disturbance of mood needing therapy.

Patient Number Two (who had Artane® for 30 days) offered further evidence of the correlation betwen behavioral ratings and L-Dopa therapy. Although he showed features of mild depressive illness the manic rating was not appreciable until satisfactory L-Dopa was

TABLE 1

CHARACTERISTICS OF THREE PATIENTS INVESTIGATED DURING L-DOPA THERAPY FOR PARKINSON'S DISEASE

Patient	1	2	3
1. Sex	M	M	F
2. Age (years)	43	53	53
3. Duration of Parkinsonism	3 yrs.	4 yrs.	4 yrs.
4. Length of Investigation	111 days	91 days	17 days
5. Evaluation (Psychiatric)	Mild depression	Mild depression	No illness
6. Initial Automated MMPI	Depressive with episodic somatization reaction	Depressive and somatization reaction with anxiety overlay	No psychiatric illness
7. Physical State	Improved	Improved	Improved
8. Final MMPI	Improvement in depressive symptoms	Not repeated	No change

TABLE 2

TEMPORAL RELATIONSHIP BETWEEN DOSAGES OF L-DOPA, SUBJECTIVE IMPROVEMENT IN PARKINSONIAN SYMPTOMS AND THE MOOD RATINGS

L-Dopa (G/day)	1-2	2-3	3-4	4-5	5-6	over 6
Subjective Improvement	None	Doubtful	Minimal	Moderate	Marked	Marked
Range of Mood Ratings:	Depressive/Manic					
Patient No. 1	1-4/1-5	0-1/0.5-1	0.5/1.0	0/1-3	0/1-2	0/1-3
Patient No. 2	0-1/0-1	0/0-1	0/0-1	0/1-2	0/0-1	0/0-1
Patient No. 3	0.5-1.0/0.5-1.5	0-1/0-1	0/0-1	0/0-1.5	0/1-1.5	0/1-1.5

In figures 1, 2, 3, are shown the mood changes associated with L-Dopa medication. Prior to L-Dopa medication, patient Number One displayed a combination of depressive and manic symptoms. This phenomenon is now commonly recognized. By the 35th day of continued L-Dopa administration following a placebo, the depressive components of the mood had completely disappeared. The scores for the manic components remain relatively low and unstable as the dosage increased from 2 to 4 Grams per day. Between 4 and 6.5 Grams per day the scores had become stable with occasional spikes unrelated to the changes in dosages. At no time was given. The manic scores became stable from the range of 2 to 3 Grams per day.

Patient Number Three did not show any depressive symptoms. When the dose of L-Dopa reached 3 Grams per day, she manifested significant manic symptoms recordable on the behavioral scales. As in the other two cases depressive scores were completely absent after the dosage of 4 Grams per day.

Discussion

The demonstration of mood changes (predominantly manic in type) in phase with

the increase in the dosage of L-Dopa during the treatment of Parkinson's disease is not as easy to interpret as implied by Bunney, *et al.*[1] who studied a patient suffering only from depressive illness. Our findings do not suggest a clear-cut casual relationship between mood changes and the doses of L-Dopa only, because improvement in the Parkinsonian

Figure 1

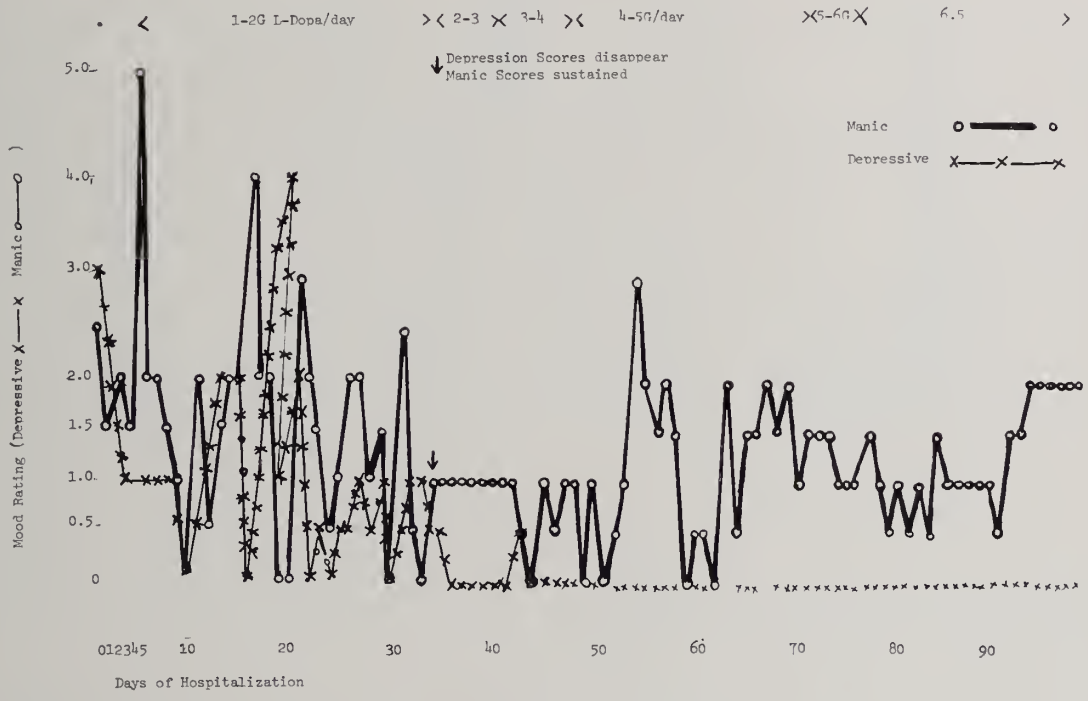


Figure 2

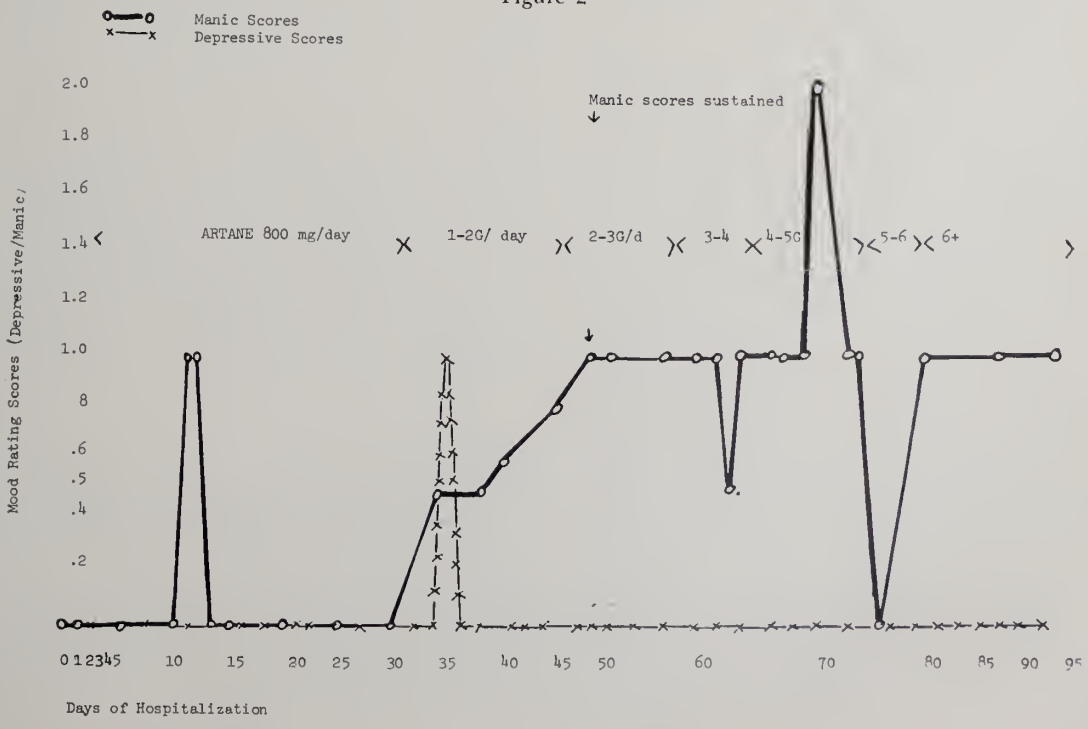
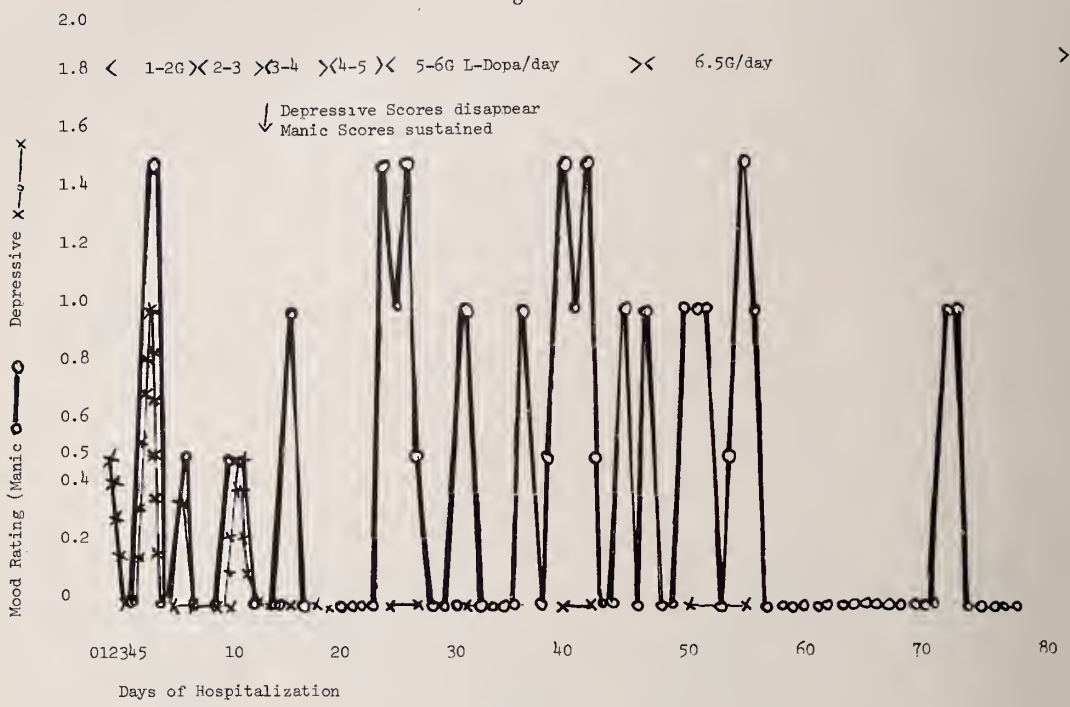


Figure 3



symptoms would ordinarily affect the patient's mood. We know[12] that depressive illness with paranoid ideation is a common concomitant of Parkinson's disease. Some authors have assumed that the depressive symptoms are purely of psychogenic origin; others, for this reason have suggested routine use of anti-depressants and electroshock therapy. The absence of depression in Patient Number Three would appear to contraindicate the routine use of anti-depressant therapy. We noted a suppression of depressive symptoms by oral administration of L-Dopa at the dosage around 3 Grams per day in two cases and the subsequent sustaining of manic scores in all three cases after this dose had been reached. This calls to question the views of Pare and others[13] and appears to support the notion[14] that this reaction is a dosage-related biochemical phenomenon. Further support is also lent by our observations that: (a) there were no manic or depressive symptoms during the use of Artane® for 30 days in Patient Number Two; (b) the appearance of significant manic symptoms at the effective dose of L-Dopa in this case; and (c) the lack of increase in manic scores even when 5 to 6 Grams of L-Dopa per day were needed to control Parkinsonian symptoms.

Our data indicate that the change in mood during improvement in Parkinson's disease is *not* primarily psychological. The effective dosage for controlling Parkinsonian symptoms is higher than that for inducing and sustaining a mood change. In our cases, the dosage for mood changes is not the same for clinical effects in Parkinson's disease as reported by Bunney, *et al.*[8] Our findings support the observation by Cotzias and co-workers[14] that in some patients the improvement of psychic symptoms "appeared to be out of phase from physical improvement induced by L-Dopa."

Conclusion

While a cause-and-effect relationship has not been conclusively established this study provides evidence to support the serontonin theory of affective disorders. Our results suggest that (a) L-Dopa at high oral dosages can reverse depressive symptoms, confirming the observation of Bunney and collaborators[8] and contrary to the observation by earlier

workers using small doses; (b) oral dosages of L-Dopa can produce central excitation[6] similar to that observed in animals; and (c) the anti-depressant property is probably due to the rise of functional brain norepinephrine.

Our study deals primarily with patients suffering from Parkinson's disease. It has, however, provided further data on the behavioral correlates of the oral administration of L-Dopa in one patient without affective illness. Our findings contain some practical implications toward the therapeutic value of L-Dopa in depressive illness.

Acknowledgment—Mr. Buddy Sevnoski, R.N., head of the nursing staff of the Hoffmann-LaRoche Special Treatment Unit in Martland Hospital, helped with this work. Dr. James Webb and Mr. Marvin Miller of Hoffmann-LaRoche Psychiatric Research Laboratory, Nutley, provided the MMPI computer analyses. We owe thanks to Professor C. K. Aldrich, Head of the Department of Psychiatry, CMDNJ, for his interest and support. And we are grateful to Dr. Harvey Solomon, Director, Hoffmann-LaRoche Special Treatment Unit and his colleague, Dr. Robert Pocelinko, for allowing us to study their patients. In addition, thanks are due to Leo Shatin, Ph.D., who is Professor of Psychology, CMDNJ, and to Monica Berry, B.S., who is Research Assistant, Department of Psychiatry, CMDNJ.

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Youth in Turmoil is the name of a book published by the U. S. Department of Health, Education, and Welfare. The text places student protests and similar disturbances within a broad framework. Protest movements are considered from the perspectives of youth and college students in American society, the changing position of youth, and the rise of a youth subculture which includes cooperative subcultures, deviant subcultures, and rebellious subcultures. The author deals with various theories of student protest movements, and in the last chapter discusses "What Is To Be Done?" This book is part of the "Crime And Delinquency Issues" monograph series, sponsored by the National Institute for Mental Health. It provides physicians, clergymen, university personnel, psychologists, criminologists, sociologists, and others concerned with contemporary social phenomena with in-depth analyses of current issues, and supplies insights and recommendations useful in the development of approaches.

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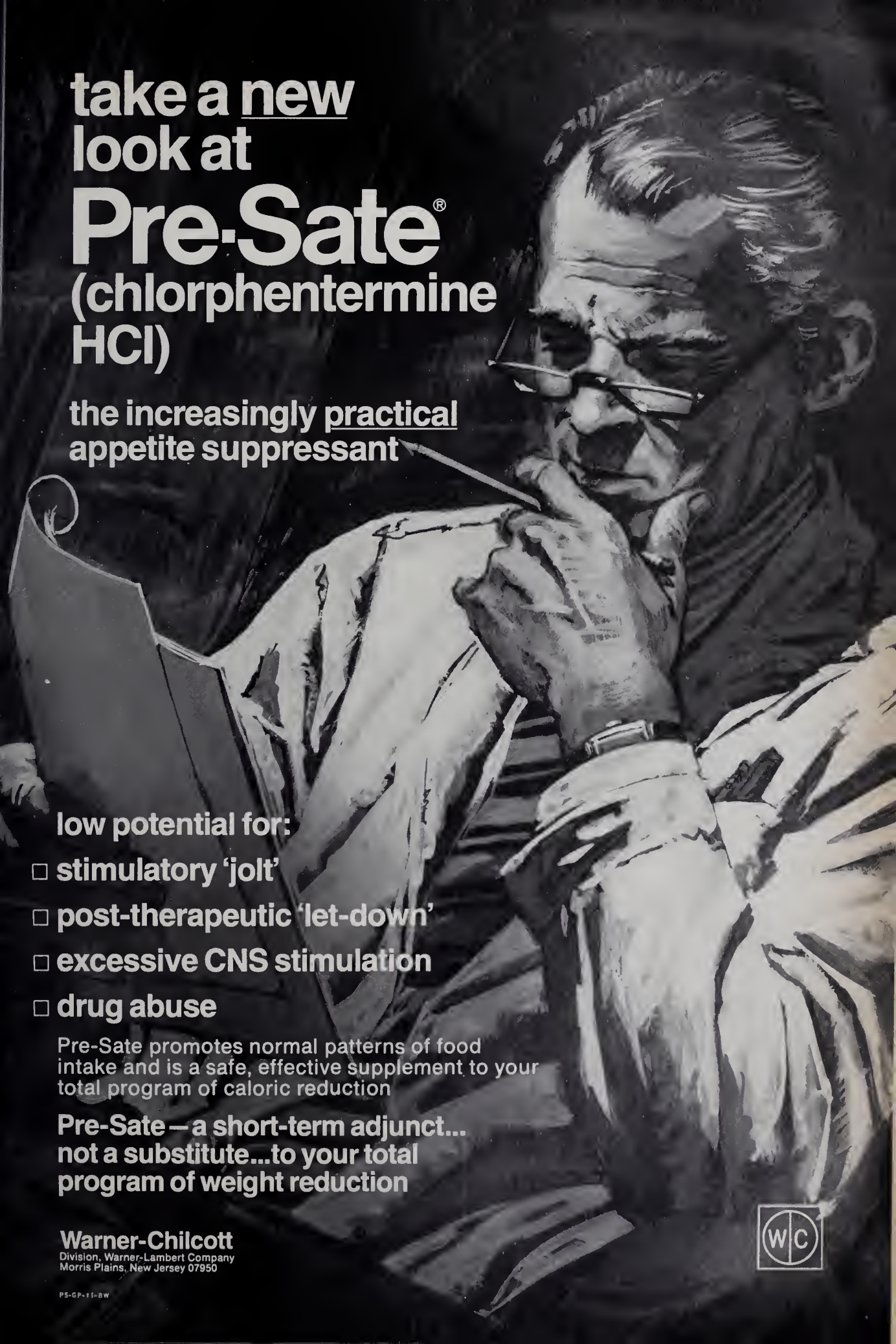
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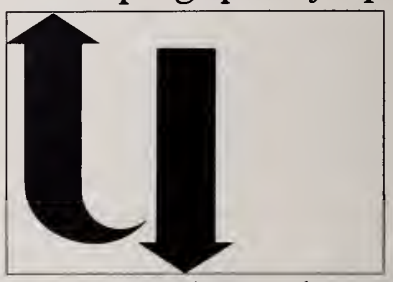

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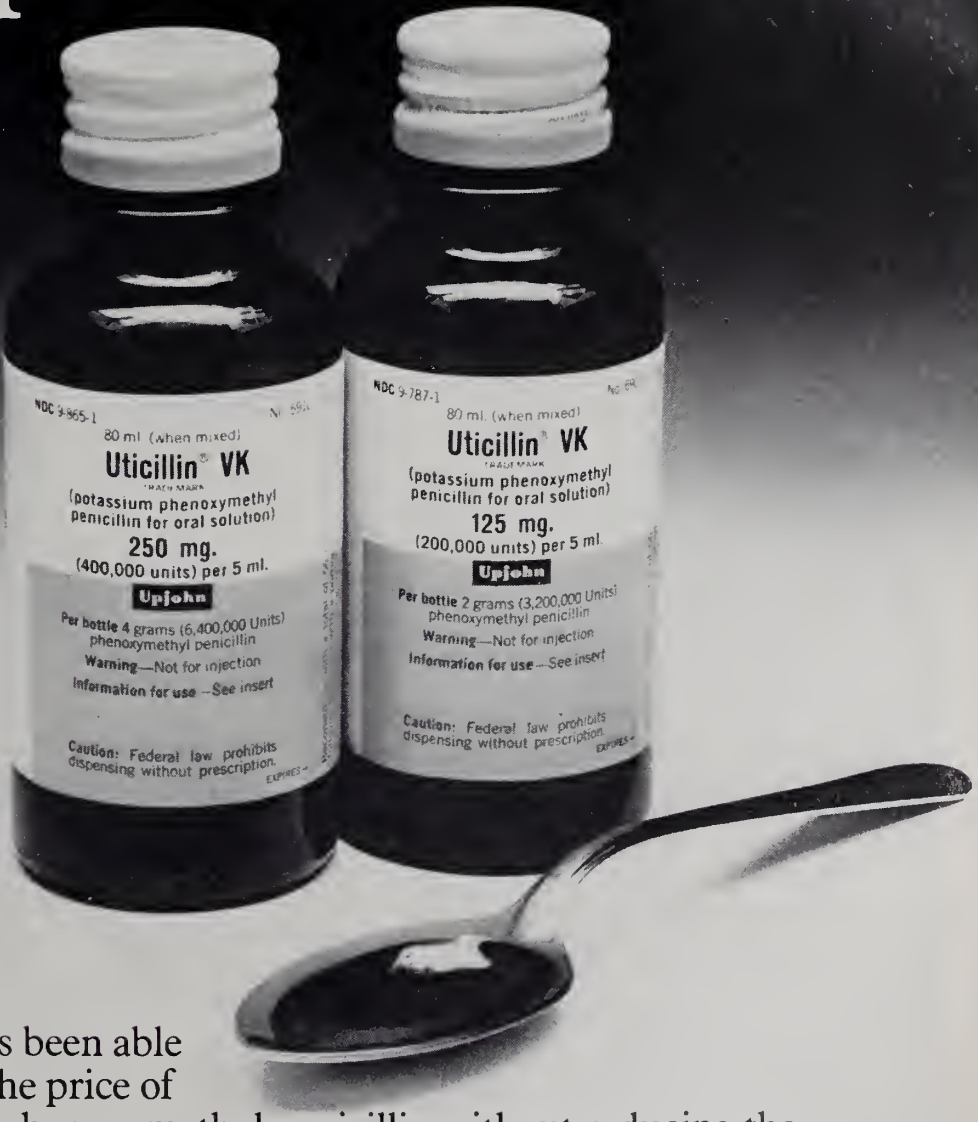
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Reconstruction of the External Ear in Children*

Richard B. Bloomenstein, M.D./Paterson

The external ear is a unique structure of complex design which is rarely noticed unless it is deformed. Such a deformity may be congenital or acquired. Regardless of the cause, the emotional effect on the pediatric patient of such an obvious facial deformity renders him subject to ridicule or, at best, pity. Early correction of the deformity in childhood presents a challenging surgical exercise.

Congenital defects of the external ear are understood best in terms of their developmental history.[1, 2] By the fifth week of neonatal life, the embryo forms six tiny elevations, three each on the first and second branchial arches. With coalescence and shifting of these mounds, the elements of the external ear are assembled. The mandibular arch elements move forward and inferiorly while the hyoid arch elements move superiorly and dorsally. Failure of the foetal ear parts to move or to develop fully accounts for formation of skin tabs and sinus tracts. The latter may be quite extensive and should be carefully excised at an early opportunity before infection and secondary fistulae make treatment more difficult.

Total absence of the ear[2] or (microtia) occurs in about one in twenty thousand births.[3] The ratio is six to one for unilateral to bilateral microtia. This condition is associated frequently with atresia of the external auditory canal, facial paresis with or without hemiatrophy and bony hypoplasia, and maldevelopment of mid ear elements. Reconstruction of the congenital microtic ear is usually undertaken, beginning at age four or five. By this time, virtually complete growth of the contralateral normal ear has occurred and it may be used as a model. Many materials have been used and others are still being tried to provide a skeletal framework for the new ear. Fresh maternal or preserved cartilage, cartilage heterografts[4] (usually ox), and a variety of synthetic alloplastic substitutes[5] have been used.[6, 7] The most popular support material today is the patient's costal cartilage. Tanzer's staged procedure[8] takes about one year and usually produces a reasonably good ear.[9] During the course of these procedures, middle ear surgery can be performed by the otologist if this is warranted. Many surgeons[10] have contributed refinements to the various steps of the auricular reconstruction. No surgically-reconstructed ear can completely duplicate the smooth intricate undulations of a normal ear, no matter how well executed. A reconstructed ear for a child and for most adults is still preferred to a prosthetic one, however, because physically and psychologically it is a part of the patient.

Protruding ears develop due to a difference in the growth rate of the anatomical ear subdivisions. The net effect of these altered growth patterns is the production of a deficient antihelical fold with a resultant increase in the scaphaconchal angle. The subjective impact of excessive protrusion of the ears from the side of the head is amusement in the observer and self-consciousness in the

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patient. Even a malformed ear is less obvious when it lies closer to the side of the head. Early attempts to attach the ear closer to the skull by excision of skin resulted, unfortunately, in obliteration of the postauricular sulcus and an unnatural appearance of the entire ear stuck to the side of the head. Most plastic surgeons[3] now use some variety of procedure to score or excise fragments of the cartilage in the region of the concha or antihelical ridge[11] or to bend the ridge or reposition it with buried mattress sutures.[12] The procedure is usually done entirely through a hidden postauricular incision. Anesthesia is general intubation in the young child but local anesthesia with sedation is feasible in a cooperative teenager. The postoperative dressing is important and utilizes cotton padding packed into the interstices of the ear to maintain the operative reconstruction and prevent the accumulation of serous fluid or blood. Follow-up care of the child after dressing removal requires further care often with wearing of a headband at night for several months.

Developmental deformities of the external ear in children include the growth of neoplasms. Benign nevi and keloids are common; malignant ear tumors in childhood are rare. Keloids, which may occur in black or white patients, usually result from definite trauma such as ear-piercing. Correction of a large keloidal deformity may involve extensive through and through resection and reconstruction of the affected part. The adjunctive injection of Kenalog® at surgery seems to help prevent recurrence. As in other ear reconstructions, pedicle flaps and skin grafts are often needed. Such procedures should be completed during early childhood.

Trauma to the auricle occurs frequently in children. The general principles of early correction apply here as well. Thorough evaluation of the patient will determine the priority of treatment in multiple system injuries (e.g., intracerebral, abdominal, and so on). Such evaluation may force delay of the ear or other facial repair. Accurate evaluation of the viability of traumatic partly-avulsed flaps may be quite difficult and require special technics.[13] Minimal debridement and accurate layered repair will enhance the chances for maximum tissue survival and good appearance of the final result. The tendency of the helical rim to notch, and for exposed cartilage to die and reabsorb are special problems requiring gentle manipulation. Secondary revisions of traumatic ear deformities can greatly improve the final result but cannot replace a properly-executed primary repair.[14] Principles of traumatic repair apply also to closure of surgical donor site defects when, for example, the surgeon uses one ear as a source of composite grafts to reconstruct defects in other facial sites (e.g. the nostril).

Burns of the external ears result in shrinkage and contracture deformities of cartilage and skin cover, usually of the helical rim. Early debridement and skin coverage during treatment of the acute burn will help to prevent progressive cartilage and skin loss from low-grade infection and chondritis. Secondary reconstructive procedures with local flaps and skin grafts can greatly improve the late result and reduce the attendant physical and psychological damage.

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Are We a Nation of Drug Users?

A research study supported by HEW's National Institute of Mental Health, Health Services, indicates that most Americans who use psychotherapeutic drugs do not take them on a regular or long-term basis. Instead, most persons appear to be relatively conservative in their use of prescription and over-the-counter psychotherapeutic drugs.

The finding was made in a survey conducted in San Francisco by the Family Research Center of the Langley Porter Neuropsychiatric Institute and the Society Research Group of George Washington University in Washington, in collaboration with the Psychopharmacology Branch of NIMH. Results are reported in the November 1971 *Archives of General Psychiatry* by Glen D. Mellinger, M.D., Mitchell B. Balter, M.D., and Dean I. Manheimer.

Studies have shown widespread acceptance and use of tranquilizers, antidepressants, stimulants, sedatives, and barbiturates—178 million prescriptions were filled in U.S. drugstores in 1967. The new sampling of American households revealed that among the users —45 per cent of the women and 33 per cent of the men interviewed—about one in five had taken drugs on a regular daily basis for six months or longer.

An important issue in the study was the extent to which persons become involved in using psychotherapeutic drugs. On this point, the survey showed further that regular long-term use is most likely to occur among those who obtain their prescription drugs from a physician. Prescription drug takers who use non-medical sources (relatives and friends) were not likely to use the drugs regularly.

Among women, prescription stimulants and minor tranquilizers rank first, with 13 per cent use. Stimulants rank first among men, with 8 per cent use. However, men also use minor tranquilizers, hypnotics, over-the-counter stimulants, and sleeping pills. Nationally, the minor tranquilizers are taken more frequently than stimulants.

Prescription stimulants are clearly the most popular drugs for persons aged 18 to 29, of either sex. Almost one out of four respondents under 30 had used stimulants on at least one occasion during the past year. The proportion using prescription stimulants drops sharply among older persons, particularly men. Men are more likely to use non-medical sources than are women.

Ninety per cent of those who sought weight control or relief of a somatic problem, such as muscular tension or a gastrointestinal disturbance, obtained their drug from a medical source. Among those who used psychotherapeutic drugs to relax or help reduce tension, about seven in ten used a medical source. Half of the people who used drugs for sleeping problems obtained them from a physician. The physician is generally the source for weight control and somatic problems, less likely to enter the picture for relief of tension or sleeping problems, and least likely to be consulted when the desired action, from the user's view, is stimulation.



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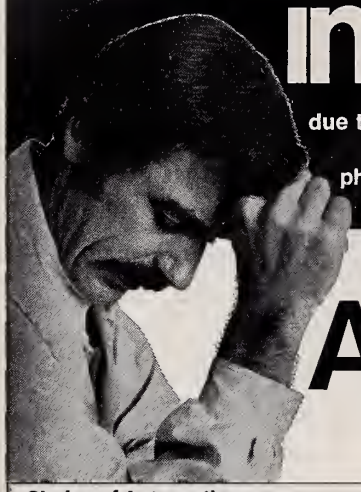
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The medical complications of alcoholism combined with malnutrition can lead to fatal metabolic disorder.

Sudden Death and Metabolic Derangement in Alcoholism with Malnutrition*

Michael A. Nevins, M.D. and Leonard J. Lyon, M.D./Paramus

A 35-year old woman was hospitalized because of weakness, anorexia, nausea, and dyspnea of several days' duration. She had lost 70 pounds in the preceding eight months because of heavy alcohol ingestion plus poor nutrition. She had been subsisting largely on baby foods.

She had been hospitalized six months previously because of epigastric pain radiating to the back. At that time she had amenorrhea and gave evidence of muscle wasting and hepatomegaly. The patient improved and was discharged on multiple vitamins.

One month later she was readmitted with similar complaints of epigastric pain and nausea. Serum amylase was normal but the 2 hour urinary amylase was slightly elevated to 278 Somogyi units (upper limit of normal is 260). Hematocrit was 31 per cent and urinalysis revealed one plus glycosuria, pH 6, and was positive for barbiturates. The patient signed out against advice after three days and was not seen again until the present admission.

At this time the patient appeared emaciated, but not grossly dehydrated. Abdominal pain was neither aggravated nor relieved by eating. Vital signs were normal except for sinus tachycardia of 128 and deep respirations at a rate of 28. There were no other cardiorespiratory abnormalities. Other than hepatomegaly (2 finger breadths) and slight epigastric tenderness, the physical examination was unrevealing. Chest x-ray showed a small infiltrate at the right costophrenic angle. The remainder of the lung fields was clear and there was no cardiomegaly. Electrocardiogram demonstrated sinus tachycardia with minor non-specific ST depressions and prolonged QT interval of .38 seconds (normal for rate is .30 seconds).

Laboratory data were as follows:

Hours after admission	*Na*	*K*	*Cl*	CO_2	*BSugar*
4	131	3.1	105	10.4	88
7	136	2.8	111	12.8	212
24	133	3.0	102	17	110

The patient was given intravenous saline and a total of 222.5 mEq of sodium bicarbonate and 120 mEq of potassium chloride. The serum potassium did not rise to greater than the original value. Thirty hours after admission and shortly after being checked by nurse (and considered stable) she suddenly developed cardiac and respiratory arrest and died.

At autopsy she weighed only 90 pounds. The heart weighed 220 Grams and was unremarkable except for a flabby consistency. On microscopic examination, there was marked hydropic vacuolar degeneration most promi-

*This work is from the Bergen Pines County Hospital at Paramus, where Dr. Lyon and Dr. Nevins are co-directors of medical education. Coauthors of this paper include Julian Joseph, M.D. and Te Hung Woo, M.D., who are Associate Pathologist and Assistant Pathologist at that hospital.

nent in the subendocardium. Some fibers were enlarged and others atrophic and some undergoing myocytolysis. The pathologist reported moderate separation of fiber groups consistent with interstitial edema. He found focal interstitial scarring moderately severe particularly in the subendocardium. No active inflammation was noted although scattered lymphocytes and plasma cells were observed in the epicardium. The liver was enlarged and weighed 1930 Grams. There was severe fatty metamorphosis. Alcoholic hyaline bodies were not seen. There was occasional canalicular cholestasis. Portal tracts were widened with septa formation and slight inflammatory cell infiltration predominantly with lymphocytes. Microscopic examination of the pancreas revealed marked atrophy of the parenchyma with fibrosis, focal chronic inflammatory cell infiltration and marked autolysis. The remaining islets did not show significant changes. The esophagus showed dilatation of submucosal veins.

The most striking abnormality at the time of admission was the low serum bicarbonate. In the absence of any clinical evidence of respiratory alkalosis, this was presumed to be due to severe metabolic acidosis although confirmatory arterial studies were lacking. There was no history of ingestion of acidifying agents, laxatives, or prolonged diarrhea. The initial impression of the house staff was diabetic acidosis because of hyperglycemia, ketosis, and acidosis. Disturbing features, however, were the absence of glucose from urine despite a blood glucose of 300 and profound acidosis in the face of relatively mild hyperglycemia. In addition, untreated diabetic acidosis is ordinarily associated with hyperkalemia. In this case ketosis could be attributable to malnutrition and mild carbohydrate intolerance to combined hepatic and pancreatic dysfunction.

Other causes of metabolic acidosis were considered. The low blood-urea nitrogen probably reflected hepatic disease and/or starvation and excluded uremia. Although lactic acidosis can result from prolonged starvation,[1] alcoholism,[2] liver disease,[3] or mild diabetes, the plasma lactate was normal and there was no anion gap or hyperuricemia. The absence of anion gap also rules against diabetes, uremia, and salicylate or methanol poisoning as causes of acidosis. Note the urine pH of 6 in the presence of apparently severe acidosis. Although the patient was dehydrated clinically, the urine specific gravity was only 1.011. These suggest renal tubular acidifying and concentrating defects. Furthermore, the extreme hypophosphatemia, hypocalcemia, and hypokalemia (the latter refractory to replacement therapy) were distinctly abnormal. This combination of abnormalities characterizes renal tubular acidosis. Unfortunately, urinary electrolytes and phosphorus were not obtained to confirm this presumption. The fundamental abnormality in renal tubular acidosis is inability of the distal tubule to maintain a normal maximum hydrogen ion gradient and to reabsorb bicarbonate. The disorder is defined by the functional inability of the kidney to respond to the stimulus of exogenous or endogenous acidosis by acidifying urine to a pH of 5.0 or less. In the presence of acidosis, urine pH of 5.0 to 5.4 indicates relative tubular dysfunction and in our patient the urine pH of 6.0 is distinctly abnormal considering the low serum bicarbonate. Among the causes of renal tubular dysfunction are alcoholism,[4, 5] starvation[6] and potassium loss.[7]

In Laennec's cirrhosis acidifying defects may be more common than generally appreciated, and acid-loading often reveals defective conservation of potassium even in the presence of normal aldosterone.[4] Patients with this defect are particularly susceptible to the development of hepatic coma after diuretics, portacaval shunts, or gastrointestinal bleeding.

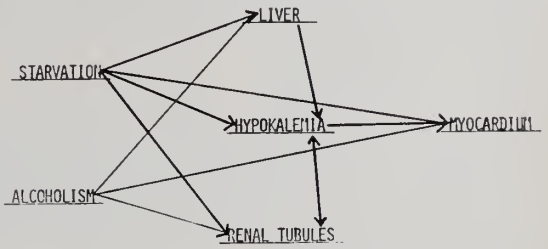
Hypokalemia is an infrequent metabolic result of therapeutic starvation for obesity with a breakdown of electrolyte homeostasis due to renal tubular dysfunction proposed as the cause. Generally, potassium loss tapers off after a few days, but there have been several case reports[6, 8] of severe hypokalemia related to starvation. Similarly hypokalemia due to

laxative abuse or diuretics[9] has been described as a cause of renal tubular acidosis and of hypophosphatemia.[10] Hypophosphatemia secondary to renal tubular dysfunction has also been described in patients with alcoholism and liver disease[5] and may be associated with symptoms of weakness, anorexia, and malaise.[11] In addition, phosphorus depletion may have a profound effect on red cell glucose utilization, lactate production and hemoglobin-oxygen affinity[12] so its deficiency may have had an important influence on the metabolic derangements in this patient.

The mechanism of death in this patient was most likely cardiac since no anatomic explanation for sudden death was discovered at postmortem examination. Acidosis and/or electrolyte abnormalities are well known causes of cardiac arrhythmias. At the time of death the carbon dioxide had increased to 17 mg per cent. Alkali therapy in addition to insulin, presumably drove potassium intracellularly, altering the intracellular/extracellular gradient. The serum potassium did not increase despite replacement therapy. In this setting, another possible cause of ventricular arrhythmia could have been hypomagnesemia, but unfortunately, this was not tested.

Myocardial disease in this patient is not surprising. Severe potassium depletion alone may cause myocardial changes.[13] Damage to the myocardium by ingestion of alcohol in the absence of malnutrition is similar to that associated with ischemia and anoxia, as well as that caused by deficiency of potassium and magnesium.[14] One of the first myocardial changes in alcoholic cardiac disease is the appearance of edema. It also causes fragmentation of the contractile elements. In one report fatal ventricular fibrillation developed in an otherwise healthy 20-year old girl who had been on a therapeutic starvation diet for 30 weeks. In that case there was no demonstrable electrolytic abnormality nor a history of alcoholism and postmortem examination[15] revealed gross loss and fragmentation of myocardial fibrils.

In our patient a combination of factors including starvation, alcoholism, and electrolyte inbalance may have interacted to cause renal tubular dysfunction, fatty metamorphosis of the liver with fibrosis, chronic pancreatitis, and myocardial damage (see figure).



It is impossible to single out one abnormality as the most decisive. The functional results were severe metabolic acidosis, hypokalemia, hypophosphatemia, mild carbohydrate intolerance, and death presumably from cardiac arrhythmia. This case exemplifies the complex interactions of multiple end organ failure and metabolic derangements resulting from alcoholism and malnutrition.

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15. Garnett, E., *et al.: Lancet,* 1:914 (September 1969)

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It would be ironical if in seeking to improve our emergency departments, we forget the indispensable nurse.

Emergency Department Nurses

Jack R. Karel, M.D./Hillside*

With the rapid annual increase of patients requesting care in emergency rooms, it is clear that nurses in emergency departments must have knowledge, skills, and greater capabilities in assisting emergency department physicians. Accidents on the highway, at home, at work and at play—suddenly, violently, and without warning—have resulted in disabling injuries ranging from partial loss of a finger to blindness or complete crippling. These injuries are now taxing the emergency services in every general medical and surgical hospital where emergency departments exist. These injuries plus the greater demand for medical treatment of non-emergency ailments necessitate a greater specialization of nurses training for assignment to those emergency departments.

Just as these emergency department physicians must now have a greater capability to cope with the varied emergency medical and surgical conditions, so must the assigned nurse be capable of performing technical procedures to free the emergency physician to give more rapid and efficient service. A nurse assigned to emergency departments must be emotionally stable enough to withstand the onslaught of multiple victims of disaster, be able to work rapidly, and be capable of procedures that heretofore were done primarily by interns, residents, or practicing physicians. The following technical procedures should be taught to the nurse who is to be assigned to an emergency department:

1. Intravenous therapy—intracath insertion
2. Withdrawing blood
3. Electrocardiogram—preparation of graph
4. Insertion of airways—resuscitube
5. Manipulation of Ambu bag
6. Simple splinting—temporary
7. Nasogastric intubation
8. Stopping of hemorrhage—with instruments if necessary
9. Emergency care of eyes
10. Debridement of wounds and burns
11. Management of the Thomas leg splint
12. Bandaging of all types
13. Use of inhalation therapy in emergency situations, such as respirator and intermittent positive pressure breathing equipment

Training programs have been initiated for emergency department physicians throughout the nation. Programs have been mandated to train ambulance attendants as emergency medical technicians. Yet there now exists a serious void for training of emergency department nurses.

To accomplish specialized training for emergency department nurses, nursing schools throughout the nation (and all general hospitals) must develop training programs on a continual basis. Medical societies and physicians individually should cooperate in their development.

* Doctor Karel is Emergency Department Physician, Saint Elizabeth Hospital, Elizabeth, New Jersey and Chairman of the Committee on Emergency Medical Care of The Medical Society of New Jersey.

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WARM LINE

clinical management/ drug abuse crises

Practicing physicians can expect to be confronted at almost any time with a medical crisis related to the misuse of psychoactive drug substances. Increasing numbers of people are misusing these drugs and a dramatic increase in the number of drug-related medical crises has been noted during the past several years.

Although much information on this subject has been disseminated, the need for practical advice on basic clinical management of these crises has become greater.

Three physicians, each of whom has had extensive practical experience in dealing with drug abuse problems, have created a series of three-minute audiotapes detailing basic medical approaches to the most frequently encountered drug abuse crises.

Dr. David E. Smith is Director of the Haight-Ashbury Medical Clinic in San Francisco, California, and Assistant Clinical Professor of Toxicology, University of California Medical Center at San Francisco.

Dr. William Abruzzi was Medical Director of both the Woodstock and Powder Ridge Rock Festivals and is currently the College Physician, State University of New York at New Paltz, New York.

Dr. Edward C. Senay is the Director of Clinical Research for the Illinois Drug Abuse Program and Associate Professor of Psychiatry at the University of Chicago School of Medicine, Chicago, Illinois.

Their taped discussions are on automatic telephone equipment for utilization at all times. The opinions given regarding treatment modalities are those of the physician speaking.

Amphetamines	**Dr. David E. Smith**
Hallucinogens	**Dr. William Abruzzi**
Opiates	**Dr. Edward C. Senay**

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

December 19, 1971

A regular meeting of the Board of Trustees was held on December 19, 1971, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

SAMA Medical Education and Community Orientation Project . . . Agreed to endorse the Medical Education and Community Orientation (MECO) Project developed by the Student American Medical Association, which places pre-clinical students in communities for summer education experiences so as to expose them to community medicine before they make a decision to specialize, thus enabling them to be more knowledgeable about their eventual type of practice and their geographic location. (This program will be initiated in New Jesery during the summer of 1972.)

. . . Directed that the entire matter be referred to the Committee on Medical Education for implementation.

Use of Physical Therapy Modalities by Chiropractors . . . Recorded itself as unanimously affirming the letter of December 9, 1971, addressed by the Executive Director of MSNJ to the Secretary of the State Board of Medical Examiners, expressing strong opposition to the State Board's proposed rule, published in the *New Jersey Register,* Volume 3, No. 12, December 9, 1971, which reads as follows:

"Physical therapy measures and modalities as defined by N.J.S.A. 45:9-37.1 (b) may be utilized by a Chiropractor provided that such measures and modalities may be employed only in preparing a patient for and as an essential aid to Chiropractic manipulative therapy. Physical therapy may be administered at the specific direction of a Chiropractor by a Registered Physical Therapist provided that such physical therapy services shall be limited to preparing a patient for and as an essential aid to Chiropractic manipulative therapy."

. . . Directed that the State Board of Medical Examiners be informed of this action by official communication and that permission to discuss the proposed new rule at the next meeting of that body be requested.

. . . Directed that a copy of the aforementioned official communication to the Secretary of the State Board of Medical Examiners be transmitted to the Attorney General, and that the matter be brought to the attention of the component societies, specialty societies, and the Health Insurance Council to stimulate them to register similar protests.

Conference on Use of Health Care Services . . . Authorized the Chairman of MSNJ's Council on Medical Services (Louis K. Collins, M.D.) to attend (with expenses paid) the Conference on the Efficient Use of Health Care Services to be held on January 13 and 14 in Chicago. The conference is sponsored jointly by the AMA Council on Medical Services, the American Hospital Association, the Blue Cross Association, and the National Association of Blue Shield Plans.

Congress on Medical Education . . . Authorized the Chairman of the Committee on Medical Education (James A. Rogers, M.D.) to attend the 68th Annual Congress on Medical Education, to be held in Chicago, February 3 to 6.

Committee on Medical Defense and Insurance . . . Approved the following recommendations from the Committee on Medical Defense and Insurance:

(1) If a member of the Society has a total of six or more claims filed against him in a five-year period—which are determined non-defensible by the county

MRAC and involve settlement of $1,000 or more respectively—such member shall be notified that he will not be recommended as eligible for renewal at the anniversary date of his policy.

(2) That when a decision to settle a case has been reached by a majority of 75 per cent or more of those present at the Medical Review and Advisory Committee meeting, the insured physician must abide by their decision and give his full cooperation—signing the necessary consent form—or forfeit his right to future coverage in the MSNJ program. If the physician continues to refuse to settle, he will be advised that his policy is not renewable at the next anniversary date, *provided the judgment of the Committee is upheld by the court decision.* (Italics indicates amendment by the Board of Trustees.)

Malpractice Hearings . . . Authorized the Chairman of the Committee on Medical Defense and Insurance (William J. D'Elia, M.D.) and Mr. Joseph A. Britton to officially represent MSNJ at the DHEW hearings on malpractice to be held February 25 and 26 in New York City.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Kin Siu Tam, M.D., 320 East North Avenue, Pittsburgh, Pennsylvania 15212. South China Medical College 1958. Hospital. Available July 1972.

Vilas R. Herekar, M.D., 37-20, Apt. 5P, 83rd Street, New York 11372. Grant 1964. Group or partnership. Available.

Bakula I. Desai, M.D., 40-39 Junction Boulevard, Corona, New York 11368. Baroda (India) 1965. Institution. Available.

CARDIOLOGY—H. Robert Silverstein, M.D., 3B Powell, Westover Air Force Base, Chicopee, Massachusetts 01022. Ohio State 1965. Board certified. Group or institution, administrative, teaching. Available.

CARDIO-THORACIC SURGERY—F. I. Ehrenstein, M.D., U. S. Naval Hospital Memphis, Millington, Tennessee 38053. Istanbul 1962. Board certified. Partnership, solo. Available March 1972.

GASTROENTEROLOGY—Arthur Tuch, M.D., 914 South Avenue, Apt. G6, Secane, Pennsylvania 19018. NYU 1965. Board eligible. Partnership or group. Available November 1972.

Kambiz Azmudeh, M.D., 700 Riddle Road, #16, Cincinnati, Ohio 45220. Tehran 1964. Board eligible. Group or partnership. Available July 1972.

GENERAL PRACTICE—Michael F. O'Connor, M.D., 15,520 Windmill Pointe Drive, Grosse Pointe Park, Michigan 48230. University College, Cork, Ireland 1970. Solo. Early 1972.

R. Jackson Dykes, M.D., Box 304, Allenwood 08720. Baylor 1967. Locum Tenens. Available January 1972.

INTERNAL MEDICINE—Nicholas A. Cannarozzi, M.D., 1 Hemlock Hill Road, Clinton, Connecticut 06413. Hahnemann 1965. Board eligible. Subspecialty, rheumatology. Association, partnership, or solo. Available July 1972.

Edward J. Feller, M.D., 4287-1 Wilmington Drive, Andrews AFB, Washington, D.C. 20331. State University of New York 1965. Board certified. Subspecialty Gastroenterology. Partnership, group, or hospital-based. Available, summer of 1972.

Yong Hak Park, M.D., 1130 Stadium Avenue, Bronx, New York 10465. Woo-Suk University, Seoul, Korea. Sub-specialty, cardiology. Board eligible. Hospital or group. Available January 1972.

David S. Rosenthal, M.D., 4 Woodland Street, Natick, Massachusetts 01760. NYU 1963. Subspecialty, endocrinology and nuclear medicine. Board certified. Group or partnership. Available July 1972.

Robert Schnitzler, M.D., 11 Fillat Street, Staten Island, New York 10314. SUNY at Buffalo 1965. Board certified. Subspecialty, cardiology. Group or fulltime hospital. Available July 1972.

Stephen M. Druckman, M.D., 3910 Powelton Avenue, Philadelphia, Pennsylvania 19104. Jefferson 1967. Board eligible. Subspecialty, gastroenterology. Partnership or group. Available July 1972.

T. N. Paul, M.D., 2900 South Lincoln Avenue, North Riverside, Illinois 60546. Calcutta Medical 1954. Board eligible. Subspecialty, endocrinology. Group, partnership, or institutional. Available July 1972.

OBSTETRICS AND GYNECOLOGY—Vellore Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board eligible. Group partnership, institution, or solo. Available.

Shi-Han Oh, M.D., 13-C Concord Cove Apts., Havre De Grace, Maryland 21078. Seoul University (Korea) 1960. Board eligible. Group or partnership. Available January 1972.

OPTHALMOLOGY—John H. Park, M.D., 741 South Gunderson Avenue, Oak Park, Illinois 60304. State University of New York 1966. Partnership or solo. Available January 1972.

Frank J. Grady, M.D., 4800 Fort Crockett Boulevard, Galveston, Texas 77550. Yale 1965. Board certified. Solo or join retiring ophthalmologist. Available March 1972.

J. Louis Pecora, M.D., 18 Tilton Avenue, Kittery, Maine 03904. Downstate Medical Center 1967. Board eligible. Association or solo. Available July 1972.

Barry F. Bader, M.D., U.S. Quarantine Station, 1365 Bay Street, Staten Island, New York 10305. New York Medical 1967. Board eligible. Group, partnership, or association. Available July 1972.

Kenette Kay Sohmer, M.D., Apt. 209, Knight House, Cooperstown, University of Kentucky, Lexington, Kentucky 40506. University of Kentucky 1968. Board eligible. Group, partnership, or solo. Available July 1972.

Ronald C. Moore, M.D., 13 West Kinney Avenue, Mount Pocono, Pennsylvania 18344. Jefferson 1919. Board eligible. Group or partnership. Available February 1972.

Gilbert B. Sussman, M.D., 16 Hopkins Road, Liverpool, New York 13088. Downstate Medical Center 1967. Group, partnership, or association. Available July 1972.

ORTHOPEDIC SURGERY—Jalal Sadrieh, M.D., 430 East 67th Street, New York 10021. Pahlavi (Iran) 1962. Board eligible. Solo, partnership, or group. Available January 1972.

H. Vossoughi, M.D., 20 Hobart Street, Welch, West Virginia 24801. Tehran (Iran) 1961. Board eligible. Solo or partnership. Available.

PATHOLOGY—John S. Weinstein, M.D., 123 York Street, Apt. 11-D, New Haven, Connecticut, New Jersey College of Medicine 1966. Board eligible. Any type of practice. Available July 1972.

Joseph W. Placer, M.D., 130th Station Hospital, APO, New York 09102, New York Medical 1964. Board certified. Group, partnership, or institution. Available September 1972.

PEDIATRICS—Kalavathi Bhupathy, M.D., 802 Gaston Avenue, Fairmont, West Virginia 26554. Bangalore (India) 1961. Board certified. Group, partnership, clinic, or institution. Available.

Nevin Esenler, M.D., 601 Roxbury Court, Apt. 3, Oregon, Ohio 43616. Ankara (Turkey) 1956. Group or partnership. Available July 1972.

Sanford S. Epstein, M.D., 621 Empire Boulevard, Brooklyn, New York 11213. University of Bologna 1965. Board eligible. Group, partnership, or association. Available July 1972.

Noel M. Wiederhorn, M.D., 42-10 Golden Street, Flushing, New York 11355. New York Medical 1969. Board eligible. Group or partner. Available July 1972.

RADIOLOGY—R. D. Kattan, M.D., 14-A Pitman Street, Somerville, Massachusetts 02143. Baghdad 1955. Board certified. Institution, hospital, partnership, or group. Available.

SURGERY—Sun Jiang Guo, M.D., Western Massachusetts Hospital, 91 East Mountain Road, Westfield, Massachusetts 01085. Taiwan University 1964. Board eligible. Associate or hospital-based. Available July 1972.

Charles P. Carroll, M.D., 5011 Caryn Court, Apt. 303, Alexandria, Virginia 22312. New York University 1965. Board eligible. Available July 1972.

Krishna K. Vadlamudi, M.D., 350 West 51st Street, Apt. 11-B, New York, 10019. Wuerzburg (Germany) 1965. Board eligible. Group, partnership, or solo. Available July 1972.

Mohammad Zafrullah, M.D., 600 West End Avenue, New York 10024. King Edward (Pakistan) 1960. Group, partnership, solo, or hospital. Available.

P. Shinghal, M.D., 115 Town Square Drive, Newport News, Virginia 23607. Indore Medical (India) 1961. Board eligible. Group or partnership. Available.

John M. Parsons, M.D., 215A 84th Street, Virginia Beach, Virginia 23451. Jefferson 1964. Board certified. Partnership or group. Available July 1972.

C. R. Chatterjee, M.D., Department of Urology, University of North Carolina Medical Center, Chapel Hill, North Carolina 27514. University of Calcutta 1958. Board certified. Subspecialty, urology. Partnership or association. Available July 1972.

N. V. Dandekar, M.D., 10 Autumn Street, #17, Boston, Massachusetts 02215. G. S. Medical (India) 1958. Board certified. Subspecialty, thoracic surgery. Group, partnership, hospital.

UROLOGY—A. Turhan Ilkay, M.D., 22 Fairhaven Boulevard, Woodbury, New York 11797 Istanbul (Turkey) 1951. Board eligible. Any type of practice. Available.

N. R. Amin, M.D., 2250 South 17th Avenue, North Riverside, Illinois 60546. B. J. Medical College (India) 1961. Group or institution. Available February 1972.

VASCULAR SURGERY—Norman M. Finkelstein, M.D., 7530 Brompton Road, Apt. 795, Houston, Texas 77025. Columbia 1965. Board eligible. Group or partnership. Available July 1972.

New Drug Testing Legislation

S-2812 has been introduced in the U.S. Senate by Gaylord Nelson (D) Wisconsin. In addition to calling for the establishment of a federal drug testing center, which would take drug testing out of the hands of the manufacturer and place it in the U.S. Food and Drug Administration, the Nelson bill would, among other things:

—Provide for the publication of a government compendium which would list all drugs available in the United States by both generic and brand name and include indications, side effects, available dosages, cost, and other information.

—Establish a committee which would compile a formulary of drugs necessary for "good medical practice" which would be reimbursable under all government financed programs.

—Prohibit the distribution of sample drugs without the written request of the physician.

—Require prescriptions to be labeled with the generic name of the drug, all active ingredients, and appropriate "warning" about potentially dangerous ingredients.

—Require that all prescription drug advertisements be precleared by the FDA. Advertisements presently are based on information included in the package insert, which must have FDA approval.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during December 1971:

	1970 December	1971 December
Aseptic meningitis	13	13
Primary encephalitis	2	3
Hepatitis: Total	363	310
Infectious	283	228
Serum	80	82
Malaria: Total	12	2
Military	12	2
Civilian		
Meningococcal meningitis	15	1
Mumps	420	32
German measles	13	29
Measles	4	69
Salmonella	104	104
Shigella	35	57

Smallpox Requirements for Foreign Travel

Recent changes in smallpox vaccination recommendations have resulted in confusion about vaccination for foreign travel.

Valid vaccination certificates are required for re-entry into the United States only for those citizens who had traveled in smallpox endemic areas within the previous 14 days. At present, smallpox endemic areas include: Afars & Issas (Africa), Afghanistan, Ethiopia, India, Indonesia, Nepal, West Pakistan, and Sudan. If citizens have traveled in these areas within the previous 14 days, and do not possess valid smallpox certificates, they will not be allowed to pass through United States customs; instead they will be placed under daily surveillance by the State and local health departments for 14 days.

The U.S. Public Health Service advises that U.S. citizens traveling to Brazil, any country in Africa, or any country in Southeast Asia should be vaccinated for their own protection.

Smallpox vaccination requirements of foreign countries were not changed as a consequence of changes in the U.S. Smallpox vaccination requirements for foreign countries vary widely and may depend on the sequence of countries visited. Therefore, if the traveler has any questions he should contact consulates of the countries which he plans to visit or the U.S. Quarantine Station in New York (212-727-2330).

Widows and Orphans Society

Support the Society for Relief of Widows and Orphans of Medical Men of New Jersey. Write to P.O. Box 95, Belleville, New Jersey, for information.

ATTENTION COMPONENT SOCIETIES

Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972.** Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972.**


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Current Status of the "Physician's Assistant"

The variety of names used to identify graduates of experimental educational programs for new assistants to the physician partially illustrates the diversity in this field—Clinical Associate, Medex, Physician's Assistant, Community Health Medic, and Medical Services Assistant to name but a few. These and other programs vary in their length of training and their requirements for entrance. Some programs are designed to utilize the background of former military corpsmen and some recruit people with various backgrounds in the health field. Still other programs are designed to offer additional training to the nurse. These diverse efforts begun by various educational institutions are producing many different kinds of "physician's assistants" to function at different levels of responsibility across a wide range of medical fields.

The American Medical Association strongly supports the concept of innovation and experimentation in utilizing health manpower. However, as the principal agency responsible for accreditation of allied medical education, it is one of the AMA's primary responsibilities to identify the need for additional categories of health manpower—specifically, what new tasks should be performed in a new occupation, and to what extent new categories of health personnel will be employed and accepted. The AMA has recommended the following working definition of the term "physician's assistant" or any other term that indicates a new health occupation with qualifications other than those of a licensed physician working in the capacity of an assistant to such a physician:

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

There is strong preference within organized medicine for the term "physician's assistant" as opposed to "physician's associate," since use of the latter term commonly implies another physician and is, therefore, confusing.

Specific job descriptions listing potential functions and responsibilities for personnel developed to assist the *orthopedic surgeon, urologist,* and *internist and family physician* have been endorsed by representatives of the appropriate medical specialty organizations.

The legal status of "physician's assistants" has been defined by a number of state legislatures. Two regulatory mechanisms for "PA's" have been proposed or enacted. Both vest authority in the State Board of Medical Examiners, or similar state agency, to regulate "physician's assistants" or classes of non-licensed allied health personnel trained to perform services in a dependent relationship to physicians. One mechanism provides an exception to the state's Medical Practice Act that codified the physician's legal right to delegate routine patient-care functions to qualified nonphysicians. The following states have enacted such exceptions: Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Kansas, Oklahoma, and Utah. Legislation has been enacted in other states to authorize the State Board of Medical Examiners to approve training programs for "physician's assistants" and approve a physician's use of no more than two graduates of such programs: California, Indiana, Iowa, Florida, Kansas, New Hampshire, New York, Oregon, and Washington. Comparable legislative proposals were pending in 1971 in Alabama, Alaska, Illinois, Maryland, Michigan, Minnesota, Nebraska, North Carolina, Ohio, Pennsylvania, Tennessee, West Virginia, and Wisconsin.

It is anticipated that standards for their education will be established by the AMA Council on Medical Education. The AMA Council on Health Manpower is currently studying a proposal for establishment of a national program for the certification of assistants to the primary care physician.

ANNOUNCEMENTS

Drug Abuse Symposium

Under the heading of "Bold New Approaches to the Drug Abuse Problem," a seminar has been scheduled for Wednesday, February 9, at the Holiday Inn, Route 1, in New Brunswick. Keynote speaker will be Herbert J. Stern, U.S. Attorney for New Jersey. Speakers include representatives of the State Health Department, State Department of Education, and the office of New Jersey's Attorney General. William Furst, M.D., will discuss the drug problem among young people.

The program starts at 9:30 a.m. and should be over by 4 p.m. Sponsors of this symposium include our State Departments of Health, Law, and Education, the New Jersey Association for Mental Health, our State's Pscyhological Association, and the New Jersey Bar Association. For reservations and additional information, write to Dr. Sylvia Herz, 220 Tillou Road, South Orange, New Jersey 07079.

Academy of Family Physicians

The New Jersey Academy of Family Physicians will hold its annual convention and scientific program March 5 to 8 at the Host Farms, Lancaster, Pennsylvania. The scientific sessions, featuring outstanding specialists in surgery, rehabilitation, and counseling, carry 12 AAFP credit hours.

Planned social programs are included in the four-day meeting. There will be special daily events for wives. Additional information is available from NJAFP, 144 Harrison Street, East Orange, New Jersey 07018.

Clinical Application of Basic Sciences

The Burlington County Memorial Hospital announces the following programs for March, in its series, "Clinical Application of Basic Sciences." AAFP will credit one and a half points per session.

March 9 Family Life Problems in Medicine
March 16 Geriatric Psychiatry
March 23 Alcohol: The Unglamorous Addiction
March 30 Descent into Hell

All presentations are held in the T. J. Summey Building of the hospital and begin promptly at 3:30 p.m. For further information, please contact the Burlington County Memorial Hospital, 175 Madison Avenue, Mount Holly 08060.

Trauma Course—May 1972

A graduate course on "Fractures and Other Trauma" will be presented May 10 to 13, 1972, at the Sheraton-Chicago Hotel, Chicago, by the local Committee on Trauma of the American College of Surgeons. A star-studded faculty will be headed by Walter P. Blount, M.D., Emeritus Professor of Orthopedic Surgery, Medical School of Wisconsin. He is a past president of the American Academy of Orthopaedic Surgeons and author of "Fractures in Children," of which a new edition is about to be released.

The program is for all who care for injured patients and is acceptable for 28 elective hours by the American Academy of Family Practice. The material is pertinent to general surgery, orthopedics, thoracic surgery, maxillofacial surgery, plastic surgery, and hand surgery. A special panel on the delivery of emergency medical care will be moderated by George Anast. Another on thermal injuries will be led by Dr. John A. Boswick.

To register, send $125 to the American College of Surgeons, 55 East Erie Street, Chicago. For interns, residents, and allied health personnel, registration is $30. Covered in this fee is the Chairman's reception and three luncheons.

Psychotherapeutic Drugs

"Psychotherapeutic Drugs in the Treatment of Mental Illness" is the title of a course to be held May 17, 18, and 19, 1972. The meetings will be at the Alumni Auditorium, College of Physicians and Surgeons, Columbia University, 630 West 168th Street, New York City. Fee: $150 for practicing physicians; $75 for residents.

Purpose of the course is to provide physicians with clinically useful information on psychotherapeutic drugs and their uses. The principal means of providing this information will be a sequence of lectures by a group of eminent physicians and scientists. Each lecturer is recognized as a specialist in the area on which he will talk.

To obtain additional information on the course, write to Dr. Lance L. Simpson, Director, Psychopharmacology Training Program, Department of Pharmacology, College of Physicians and Surgeons, Columbia University, 630 West 168th Street, New York 10032.

Cancer and Human Values

A unique seminar on cancer and human values will be held on Thursday, Friday, and Saturday, June 22-24, 1972, at the Regency Hyatt House, Atlanta, Georgia. The conference will be concerned with understanding the problems of the cancer patient from inception of disease to cure or failure. Also, the effects on the family and professionals who are directly concerned. Emphasis will be placed on the humanistic problems of the patient, including interpersonal relationships, rehabilitation, employability, insurability, the right to know, the spiritual needs, and the hopes for miracles.

For details, write to American Cancer Society, 219 East 42 Street, New York 10017.

EENT Surgical Meeting

Lake George will provide the cooling atmosphere for a mid-summer meeting of the EENT section of the International College of Surgeons. The place is the Sagamore Hotel at Bolton Landing, New York. The dates are July 5 to 10, 1972. For more details, write to Dr. Leon J. Schwartz, 162 Chestnut Street, Rutherford, New Jersey.

Neurophysiology Program in France in 1973

The International Congress of Electroencephalography and Neurophysiology announces a scientific program to be held the first week in September in Marseilles, France. English will be one of the official languages of the Congress. For more details, please write to Dr. G. C. Lairy, Hospital Rouselle, 1 Rue Cabanis, Paris 14, France.

National Cancer Institute Accepting Patients

The National Cancer Institute at 3100 Wyman Park Drive, Baltimore 21211 is accepting patients with leukemia, lymphoma, brain tumors, and metastatic solid neoplasms. Radiation therapy and chemotherapy are available. There is no charge to the patient for hospital care, drugs, or medical services. Patients are returned to the referring physicians with full reports. For more details, write to the admitting officer of the Cancer Research Center at the Baltimore address.

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Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

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Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1972

February

10 **Burlington County Memorial Hospital**
Mount Holly
Neurological Complications of Visceral Carcinoma

14 **Academy of Medicine of New Jersey**
St. Peter's Hospital
New Brunswick
Hodgkin's Disease

16 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Newer Concepts of Hepatitis

16 **Bergen Pines County Hospital**
Paramus
Infectious Diseases II

16 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Coronary Artery Evaluation and Surgical Approaches

17 **Burlington County Memorial Hospital**
Mount Holly
Full Time and Voluntary Staff—The Interface

17 **Fair Oaks Hospital**
Summit
Legal Psychiatry

23 **St. Clare's and Dover General Hospitals**
Auto-immune Aspects plus Transplantation

23 **Bergen Pines County Hospital**
Paramus
Infectious Diseases III

24 **Burlington County Memorial Hospital**
Mount Holly
Newer Approaches to Community Health

24 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

March

1 **Bergen Pines County Hospital**
Paramus
Interstitial Lung Diseases

1 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Cardiac Surgery

2 **Burlington County Memorial Hospital**
Mount Holly
Sterilization and Therapeutic Abortion

2 **Fair Oaks Hospital**
Summit
Encounter Group

6 **Academy of Medicine of New Jersey**
Valley Hospital, Ridgewood
Diagnosis and Treatment of Shock

8 **St. Clare's and Dover General Hospitals**
Renal Vascular Hypertension; Malignant Hypertension

8 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Valvular Heart Disease

9 **Burlington County Memorial Hospital**
Mount Holly
Family Life Problems in Medicine

14 **Academy of Medicine of New Jersey**
South Amboy Memorial Hospital
South Amboy
Renal Failure

15 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Pediatric Cardiology

16 **Burlington County Memorial Hospital**
Mount Holly
Geriatric Psychiatry

16 **Fair Oaks Hospital**
Summit
Legal Provisions for Mental Health

22 **St. Clare's and Dover General Hospitals**
Secondary Nephropathies

22 **Academy of Medicine of New Jersey**
University of Pennsylvania Hospital
Philadelphia
Clinical Gastroenterology

22 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Arteriosclerosis

23 **Burlington County Memorial Hospital**
Mount Holly
Alcohol: The Unglamorous Addiction

29 **Academy of Medicine of New Jersey and American College of Chest Physicians**
Pulmonary Physiology

30 **Burlington County Memorial Hospital**
Mount Holly
Descent into Hell

30 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

30 **Fair Oaks Hospital**
Summit
The Expert Witness

April

6 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

10 **Academy of Medicine of New Jersey**
Saint Francis Health Center
Jersey City
Proper Use of Antibiotics

12 **Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: Implantology

13 **Burlington County Memorial Hospital**
Mount Holly
Thermography

13 **Fair Oaks Hospital**
Summit
Behavior Therapy

19 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Leukemia and Lymphoma

20 **Burlington County Memorial Hospital**
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases

22 **American Cancer Society**
Rutgers Medical School, Piscataway
Role of Primary Physician in Cancer Patient

25 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Current Burn Treatment

27 **Burlington County Memorial Hospital**
Mount Holly
Diseases of the Esophagus

27 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

27 **Fair Oaks Hospital**
Summit
Behavior Therapy

May

4 **Burlington County Memorial Hospital**
Mount Holly
Syndrome of Stress Ulcer

6-9 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

11 **Burlington County Memorial Hospital**
Mount Holly
Zollinger-Ellison Syndrome

11 **Fair Oaks Hospital**
Summit
Brain Tumors

18 **Burlington County Memorial Hospital**
Mount Holly
Drug Interactions

LETTERS TO THE JOURNAL

Reaction to Guadalajara Article

December 22, 1971

Dear Sir:

The article "Guadalajara and the Foreign-Trained Physician," by S. William Kalb, M.D., which appeared in the December 1971 issue of *The Journal* of The Medical Society of New Jersey, has been brought to my attention.

I am sorry to say that Dr. Kalb has been misinformed with respect to the position of the ECFMG.

In the second full paragraph in the first column on page 1020, there are several inaccurate statements:

The ECFMG has never made any suggestion to the Autonomous University of Guadalajara that its medical curriculum be shortened. As far as we know, the shortening of the course work at that medical school from five (not six) years to four was done on the sole initiative of the medical school. Equally inaccurate is the statement that ECFMG "promised to certify the graduate for examination when he received his diploma . . . which will be issued with a degree of 'Physician and Surgeon.'" ECFMG has made no such promise, since under ECFMG policy a graduate of a foreign medical school must have completed all of the educational requirements which will entitle him to a license to practice medicine in the country in which he has had medical education before he is eligible for ECFMG certification, assuming that he has passed the ECFMG examination. In Mexico this end point is the Title of Physician and Surgeon (Titulo de Medico Cirujano). In order to receive this Title the student must complete five years of course work (four at the Autonomous University of Guadalajara), have a year of internship, a year of *Servicio Social,* and pass final examinations. The diploma which the students receive after completing the four years of course work at the Autonomous University of Guadalajara specifies that they have completed the theoretical portion of the course leading to the Title of Physician and Surgeon. It is not recognized as a university degree under Mexican law.

(signed) G. Halsey Hunt, M.D.
Executive Director
Educational Council for
Foreign Medical Graduates

A Kind Word for Academic Practice

December 15, 1971

Dear Sir:

Your editorial, "Curing is Easier than Healing" (68:973, December 1971) was an excellent statement of truths most medical schools have been teaching for many decades, and I was delighted with it until I encountered the reference to " . . . academic circles or large practice groups where medical care is dispensed more in units of treating diseases than in the more subtle effort to try to heal the whole man." I believe this is an unwarranted generalization. Academic circles and large practice groups are, by and large, just as interested in healing the sick as are the other physicians.

Admittedly, there are academic subspecialists more interested in curing than in healing, but there are also solo practitioners of this sort. I know of no evidence that one type of doctor does any better job of healing the whole man than does the other. In the absence of such evidence, I suggest that gratuitous slurs on one another's motivations and competence are ill-suited to *The Journal* of a major medical society.

(signed) Richard J. Cross, M.D.

Dr. Knauer Accoladed

Warren H. Knauer, M.D., has received the 1971 Physicians Award of the New Jersey Division of the American Cancer Society. This plaque is presented annually to a New Jersey physician for "outstanding contributions in the fight against cancer." Dr. Knauer is the clinical associate professor of surgery at the College of Medicine and Dentistry and is a member of the Executive Committee of the New Jersey Division of the American Cancer Society.

A graduate of Princeton University and Columbia University College of Physicians and Surgeons, he has had extensive training and experience in oncology at Yale, New York's Memorial Center for Cancer and Allied Diseases, and Presbyterian Medical Center. He is presently associated with the Wuester Tumor Clinic in Elizabeth and the James Green Tumor Clinic at Elizabeth General Hospital. Dr. Knauer is attending physician at the Elizabeth General Hospital's Department of Malignant and Allied Diseases and on the surgical staffs of St. Elizabeth's Hospital and Alexian Brothers Hospital in Elizabeth.

OBITUARIES

Dr. Rudolf J. Baruch

On January 3, 1972, a bullet, shot by a patient, put a dramatic end to the useful career of Rudolf J. Baruch, M.D., a prominent New Jersey psychiatrist. Born in 1904, he received his M.D. from the University of Berlin in 1928. Board certified in both psychiatry and neurology, he was affiliated with all three hospitals in Elizabeth, in which city he had his office.

Dr. Jonathan Howland

Word has just been received that on June 2, 1971, Jonathan Howland, M.D., died at the untimely age of 63. He was an emeritus member of our Mercer County Society and a 1944 alumnus of the medical school at Johns Hopkins. Dr. Howland was an internist affiliated with the Princeton Hospital. He practiced in Lawrenceville.

Dr. Joseph R. Pedevill

One of Bergen County's civil leaders, Joseph R. Pedevill, M.D., born in 1902, died on Christmas Day 1971. He was a surgeon who practiced in the borough of Palisades Park. He was a 1927 graduate of the New York Medical College, and was on the Board of Directors of the Palisades Park National Bank. At the time of his death, he was on the staff of the South Bergen Hospital at Hasbrouck Heights, and the Holy Name Hospital in Teaneck. He was an active member of our Bergen County Medical Society.

Dr. Charles J. Sullivan

One of the founders of the Roosevelt Hospital in Edison, Charles J. Sullivan, M.D., died on December 10, 1971, at the age of 86. He won his M.D. at Tufts in 1912 and was active in medical and hospital administrative circles in Middlesex County from 1913 until 1969, when he retired to Sea Girt at the age of 84. He was active in both hospitals in New Brunswick, having been an "attending" at Middlesex and chief of staff at St. Peter's.

BOOK REVIEWS

Disaster at Bari. Glenn B. Infield. New York, MacMillan, 1971. Pp. 299. Illustrated. ($7.95)

If the holocaust here described has any hero, it is a member of The Medical Society of New Jersey—Stewart Alexander of our Bergen County component. In December 1943, the harbor at Bari, Italy, was crammed with allied shipping when the Luftwaffe struck, destroying 17 ships and killing a thousand servicemen. What lent this disaster its special horror was that one U.S. vessel had a secret cargo: a hundred tons of mustard gas. Soldiers and sailors immersed in the bay were being exposed to a concentrated solution of mustard gas in sea water and developed mysterious dermatologic and ophthalmic symptoms. Dr. Alexander had had special training in the toxicology of chemical warfare and was sent as a consultant to Bari. In an effective and striking bit of medical detective work, he demonstrated that the mysterious ailment which was afflicting so many victims was poisoning by mustard gas. Many in the high command were unwilling to believe that our Army had stockpiled this chemical, but Colonel Alexander's findings were incontestable.

While the toxic effects of mustard gas are well known, no one before had the opportunity to study the result of prolonged exposure to water in which the chemical had been dissolved. Had the responsible authorities been advised in advance that one of the ships was loaded with the gas, many of the casualties, Mr. Infield suggests, might have been averted. The observations at Bari had an effect on the development of alkylating agents in treating cancer and also on the establishment of the Sloan-Kettering Institute.

The documents have just been declassified, making this interesting medical detective story possible. The narrative is written in lively and highly readable style and points up a new dimension in the annals of military medicine.

Henry A. Davidson, M.D.

Physiology of Reproduction. William D. Odell, M.D. and Dean L. Moyer, M.D. St. Louis, Mosby, 1971. Pp. 152. Illustrated. ($12)

The authors have carefully and thoroughly presented the material indicated by their title, so that it might be meaningful primarily to the graduate student of physiology. The subject matter is offered systematically, succinctly, and pedantically in eleven chapters starting with hormonology, then proceeding to the pituitary-genital apparatus, puberty, sperm and egg transport, fertilization, and finally and briefly to contraception.

The preface warned that little clinical or pathologic material or examples would be included, but their addition would enhance the value of this book. A few representative clinical and/or pathologic conditions would reinforce the physiologic concepts for the physician and would remind the physiologist of the many practical applications of the scientific material as well as the needs of the community in public health, clinical medicine, and population control. It seems unfortunate if not impractical to limit their reading public to such a relatively small segment of the scientific community; not that the authors should direct their talents to the lowest and/or broadest segment but more readable material presented in a more stimulating manner would have made the text more worthwhile. Even the graduate student of reproductive physiology would appreciate a more provocative approach and thus might be stimulated into avenues of investigation of which he might be otherwise unaware. Footnotes and an expanded list of references would provide sources of information for the more scientifically-minded and research-oriented investigator.

Although the authors have presented their material accurately, it would be difficult to recommend this book in its present form to anyone but the doctoral candidate or the research-oriented graduate physician.

Jerome Abrams, M.D.

How to Live with Diabetes (Third Edition). Henry Dolger and Bernard Seeman. New York, Norton, 1972. Pp. 208. ($6.50)

This short compendium for diabetics is the third edition of a well-established book which has long been recommended by many physicians to their patients, for better understanding of their condition, and for detailed explanation on how to follow their instructions intelligently.

The introduction, which deals with the history of diabetes from the ancient times up to the present, is fairly long for the layman and may be more useful to inquisitive interns or residents than to the average patient, who may not appreciate the multiple scientific discoveries which ultimately lead to the present concepts of diabetes and its treatment.

A youngster is abruptly shocked when he finds himself outside the circle of his friends, after he has been told that he is a diabetic. This problem is handled competently with advice to the affected person and the family. The difference between the young and maturity onset diabetes is carefully outlined.

Treatment is described in simple terms, explaining the different forms of insulin and oral hypoglycemic agents and outlining the necessity of adherence to a permanently regular way of life by eating on time and adjusting the medication accordingly.

Hereditary factors, which provide, sometimes, a very touchy problem when the patient asks for your advice about matrimony, are explained with tact to the patient without alarming him or his family. The complications of older diabetics are discussed adequately and the patient is encouraged to lead a normal life.

Diabetes is still a riddle to us—to mention only the controversy over the GUDP study. Dr. Dolger's book can be highly recommended to a new diabetic. Even old diabetics can learn many interesting items and, as a matter of fact, many practitioners can pick up a few tricks on how to handle and answer questions of a worried patient.

Otto Brandman, M.D.

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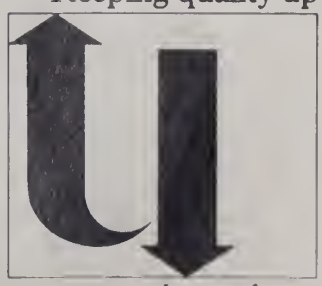
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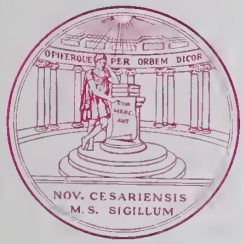
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Two developments indicate that the hue and cry over "poor quality" health ca and the deteriorating image of the physician may be considerably overstated, b the image of the profession as a whole might stand some improvement.

Nine out of 10 breadwinners are satisfied with the quality of the health care th receive, according to a nationwide survey conducted by Chicago's Center Health Administration Studies and National Opinion Research Center, wh elicited responses from 3,232 heads of households.

Support for the belief that the doctor's image is not all that bad comes from unlikely source, television. An article in the New York Times Magazine by Mich J. Halberstam, M.D., on the "Marcus Welby, M.D." show points to some reas for the program's popularity. He says in part: "Doctors, like journalists or act find it hard to remember that many people consider their jobs to be glamorc Glamour tends to fade from anything which one does daily for a living, and I, many of my colleagues, try to play down the mystique of medicine. Doctors human like everyone else, we have a job like everyone else . . .

t of course this isn't so, the TV shows are right — there's something special ut medicine (just as there is about police work or the law or lots of other upations). To a doctor, medicine really is the only proper profession, and other sicians, no matter how weird their politics or how dull the administrative jobs / may have taken, are still comrades-at-arms.

nat the viewers of 'Marcus Welby' seem to grasp and what seems to escape ne radical health workers is that elitism has its noble aspects. All of us do better k when more is expected of us, and, if we belong to an elite, more is expected. re is nothing embarrassing about membership in an elite based on learning, lication and humanity, nor does pride in one's profession mean that others inferior. . .

e public . . . knows very clearly what it expects of physicians and what it will tinue to expect of them. . . . The need for scientific knowledge, for compassion l for relentless dedication is not a trick bag decked out by the AMA, but the pest want of any human in trouble."

Chicago survey also indicated that while people feel the care they are getting ood, they tend to believe it is better than the care received by others; which ws that if you are told something often enough in the media you tend to believe ven when it is contrary to your own experience.

respect that people have for their individual physicians has been earned. If tors are to win this same respect for the medical profession as a whole, each sician must have as much pride in his profession and set as high standards for whole profession as he does for himself. This is what peer review is all about. standards of the profession can best be maintained by doctors actively porting peer review committees of their hospitals and their County and State dical Societies.

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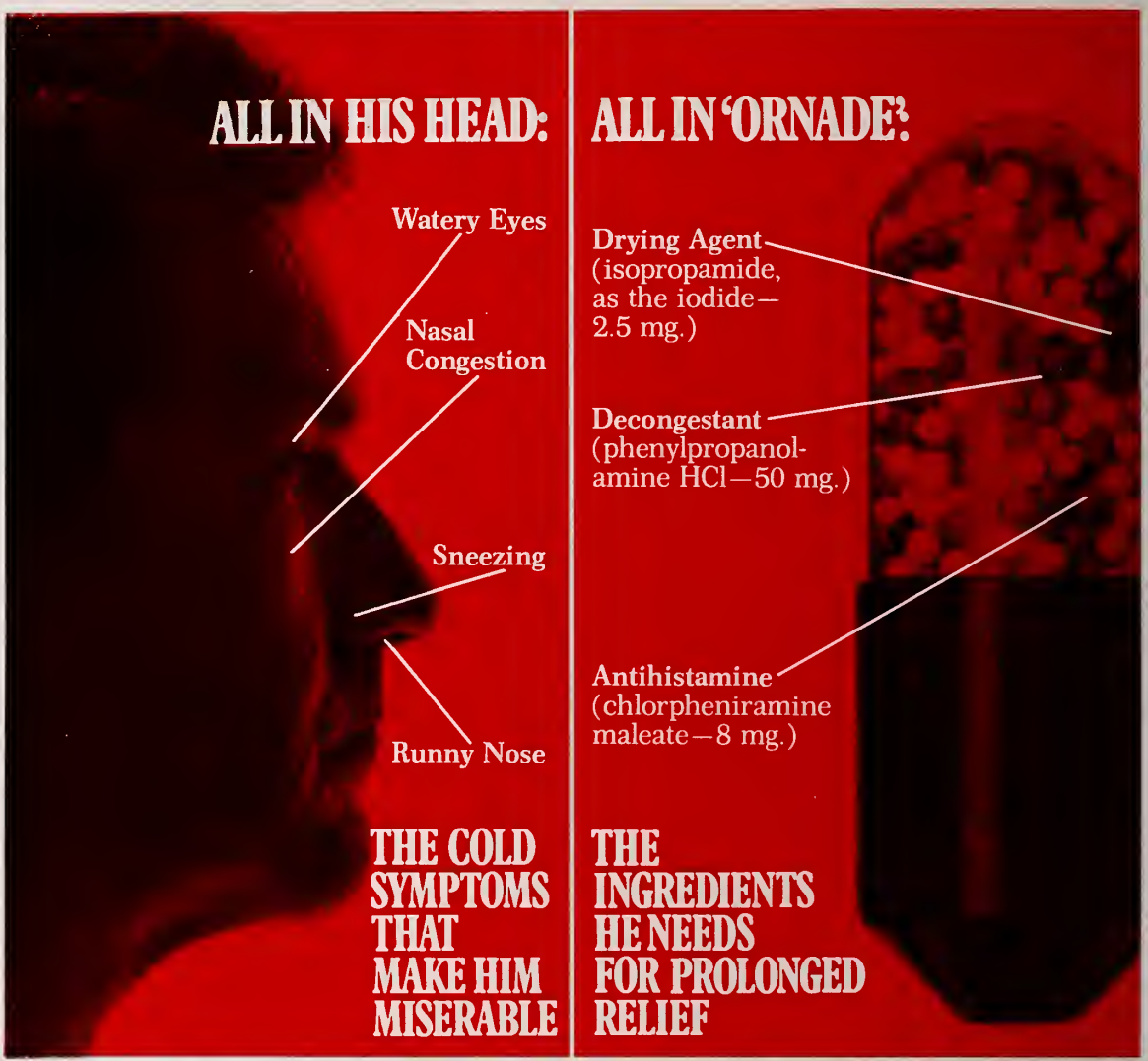
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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

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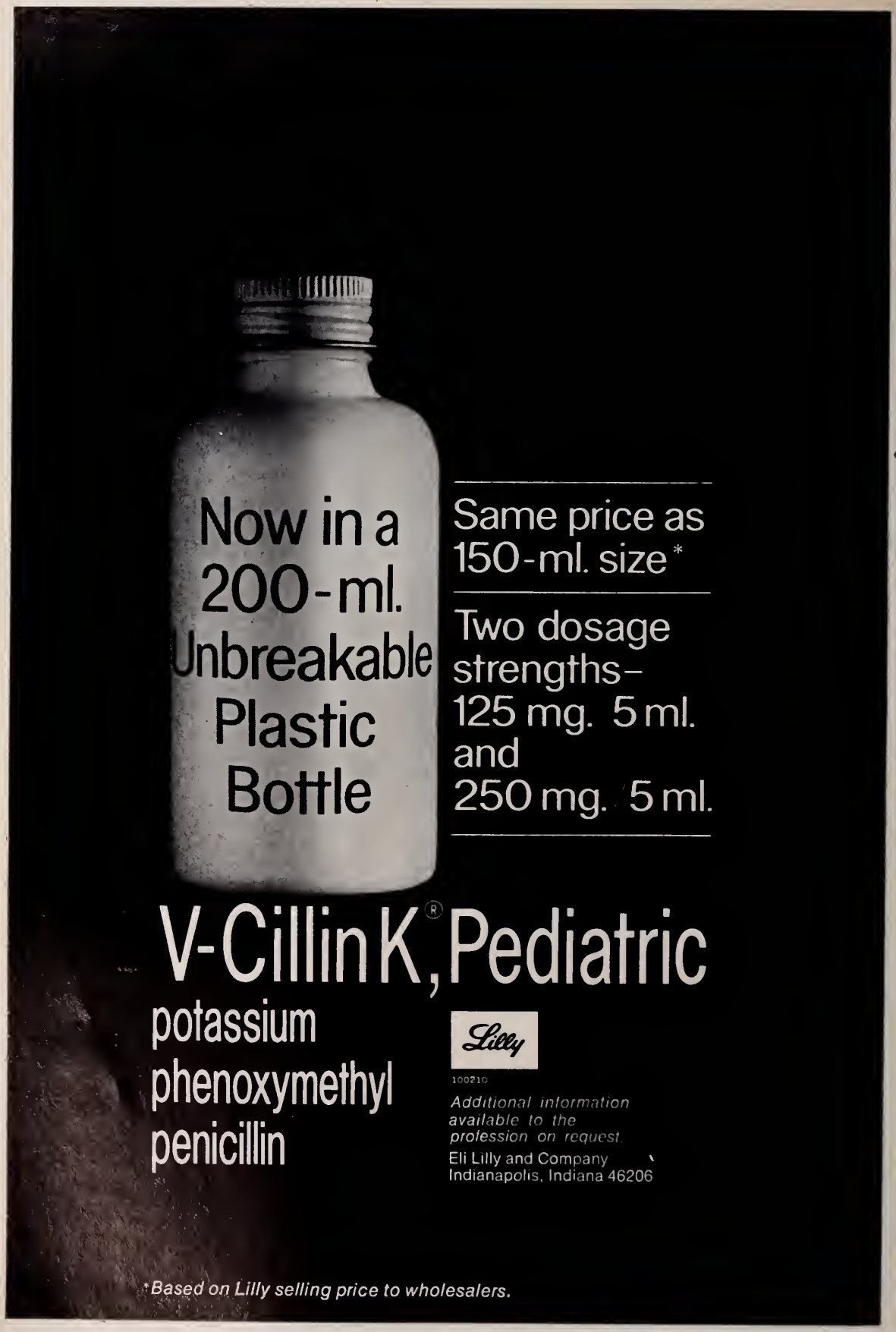
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EDITORIALS

The End of Learning

As one becomes eligible for Medicare, it occurs to the physician that he is probably not going to learn much from here on in. Not, of course, that he knows all that is to be known, but rather that, at 70, one is unlikely to pick up anything that is both new and usable.

Will one take a course in any new technic when the time available to put it into practice is so short? Suppose they gave a course on medicine for the space age. For a 26-year old doctor that would be great. But the 70-year old knows that he will never go to the moon. One's 40-year old son may not make it . . . one's grandson, probably. After all, your grandson will spend most of his life in the 21st century. But the 65-year old will probably not get out of the 20th century alive. So what would be the point in learning how to handle vascular disorders in a world without gravity? (They tell us that in a weightless world, the tears couldn't run down your cheeks!)

A man can be a good surgeon for 30 years, but he may have to give up responsibility for ward and service cases at 62. Fewer and fewer patients are asking for the senior surgeon to operate on them; and not many GP's are sending cases to 70-year old surgeons. The 70-year old may never again stand in the number one position at an operating table. So, why should he learn new surgical technics? He'll probably never use them. Look through some of the colorful photos showing new methods of anastomosing vessels or even removing hemorrhoids. It's a real chore trying to wend my way through the jungle of diagrams and illustrations . . . and for what purpose?

The 70-year old can still enjoy lots of things in life, from watching horse races to traveling through Europe. He can enjoy home and grandchildren. But he may not enjoy going to medical meetings. If they expound something complex and new there, he may have difficulty learning it. Sure, he can remember that the dose of chlorpromazine is 10 to 50 milligrams at a time and he recalls the difference between a direct and an indirect hernia. But if it's a shiny new topic, requiring a lot of creative study, can he master it? Or maybe it's just a matter of motivation. At any rate, by age 70 there are very few brand new things one is going to learn.

Medical society meetings, especially local ones, provide the opportunity to meet old friends. But there is little point in going to a medical meeting just for that purpose. One can see friends socially whenever one wants. One surgeon tells us he did go to three county medical meetings this year because they sounded, from the advance program, as if they'd be interesting. One was an illustrated lecture by a distinguished surgeon on shock. The program chairman promised that the audience would learn recent advances in (or maybe "progress in") controlling shock. Actually, they heard a lecture on electrolytic imbalance and the osmotic pressure of changing fluids. The slides were charts, graphs, and tables. Maybe some of the members learned something new. But this senior member said that he didn't see how he could possibly put to use the stuff the speaker was retailing about advanced physiology. Then there was a meeting scheduled to review the allegation that some doctors were earning five-figure amounts from Medicaid, Medicare, and welfare programs, and that this was corroding our image. Here, he did learn that the stories were exaggerated, that only a small number of us were involved, and that most of the king-sized payments were to groups or clinics. The third session was a panel on transplants. As it turned out, the whole focus was on how can you be sure that the donor is really dead before you pluck out his heart or liver. The principal speaker had worked out a mathematical formula with so many points if the electro-encephalograms were iso-electric, and so many if you couldn't hear a heart beat,

and so many if the pupils were non-reactile and dilated. No, he didn't allow points for rigor mortis. Again, the surgeon didn't really learn much, except maybe that there is no "moment of death" and that maybe death is a process, not a moment. But do you have to go to a medical meeting to learn that?

If you were born before 1910, can you figure out how a computer—a data processor—really works? Is it worthwhile learning it now?

Our friendly neighborhood actuary tells us that a male at age 65 has a life expectancy of 8 or 9 years. When our medical school class held its 40th reunion (and I was 24 when I got my M.D.), I learned that 40 per cent of our class was already dead. The figure the insurance man worked out, thus, was actual as well as actuarial. And with a life expectancy of less than 9 years, is it really worthwhile trying to learn something new? Or is life too short for that, and shouldn't we enjoy what we know we like? At age 65 one would resent it if you called him a senior citizen. We like Stieglitz's term for our age: "later maturity." Well, what makes later maturity sad is not the end of joy, not even the end of hope, but the end of learning.

Combination Therapy

The only judge, really, of the effectiveness of a fixed combination drug, is the treating physician. Some members of the FDA and its panel of eminent professorial consultants have stigmatized many fixed combinations as "irrational." Indeed, it has almost reached the point where the distribution of such a combination carries an implication that the package is "irrational." In truth, every practitioner knows (and the literature supports this conclusion) that there is such a phenomenon as synergism. Synergistic combinations have, over the years, been found to be helpful to patients. It would be wonderful if all medication could be given under scientifically ideal conditions. But at any time only a small proportion of the patient population can enjoy this ideal setting. In his daily practice, the M.D. needs all the convenience, practicality, and simplicity of regime that he can get. The "combinations" actually were evolved to meet the patient's need and the practitioner's preference. The dose ratios are carefully worked out. For the clinician to have to formulate these ratios would be awkward and often impossible. (How would you like to assay every dose and work out its compatibility with each other ingredient?). Surely it is more costly to the patient if he has to pay for a bottle of ingredient A plus a package of ingredient B. This is not to say that *all* fixed combinations are wonderful. Some of them, indeed, might be branded "irrational." But it *is* to say that the judgment must be based on the merits of the ingredients. (See October 1971 FDA guidelines on combination products, page 264, this issue.)

The Courage To Do Nothing

"Activism" is a word to conjure with these days. And it often affects our medical procedures. When the patient and the family are in distress, there is a natural call to do something—to do anything other than just to sit at the bedside. The famous Luke Fidelis portrait of the doctor at the bedside of the dying child portrays him—so it seems—as sitting there looking unhappy but doing nothing. It may be that passivity in this situation implies our helplessness, and no one likes to be thought of as impotent. One thinks of one of the aphorisms of Hippocrates to the effect that if what you can do may do harm, it is better to do nothing—or the happy phrase, "masterly inactivity," coined by Osler.

To say to the patient or family "there is nothing I can do" takes a lot of courage. In a way it is an admission not only of defeat, but also of retreat. So the obvious way out of this embarrassment is to try one more injection, one more maneuver. Yet there are times when the doctor must have the courage to do just that—to do nothing.

ORIGINAL ARTICLES

Effective mental health centers require community participation.

The Promise and Problems of Community Mental Health Centers*

C. Knight Aldrich, M.D./Newark

Although the Community Mental Health Center (CMHC), as currently conceived, is scarcely a decade old, it has roots which go back at least to the great depression which began in 1929. Prior to that time, the Darwinistic philosophy (survival of the fittest) pervaded our social thinking. By the mid 1930's, however, it had become evident that even worthy and fit people might need help. This concept, that society as a whole had a responsibility to its citizens in trouble, was one of the roots of the CMHC, as well as of public housing, Medicare, and social security.

Another stimulus to the CMHC was the development of the tranquilizers, which encouraged community care in two ways. It facilitated early discharge from mental hospitals, and thus placed large numbers of the emotionally disturbed in the community. This development also encouraged the abandonment of the kind of biologic fatalism which made so many of us feel that the patient in the back ward was hopelessly lost to society.

A third factor was derived from social science research. Epidemiologic studies indicated that people in the bottom economic and social classes had both the highest incidence of emotional illness and the poorest treatment resources. They also indicated that there was much more emotional illness, even in the best of circles, than had been suspected. A fourth factor was the reduction in the mental hospital population in Britain and Scandinavia in the 1950's, which made us wonder what they had that we didn't have.

A final factor was the increasing community acceptance of the mentally ill, which in turn can be related to three developments. One development was the appeal of psychoanalysis to the more sophisticated classes, beginning in the 1930's; a second development was improved public education, for which the mental health associations deserve primary credit; the third development was a reduction in the degree of much of the overt symptomatology of emotional illness, in part due to the newer antipsychotic and tranquilizer medications, which made the residual signs more acceptable to the community.

The combined impact of these five factors led to the Community Mental Health Center Act of 1963. The promise implicit in this act is that centers will be established all over the country to provide five services: (1) short-term inpatient care which, it was hoped, would eventually make our huge state hospitals unnecessary; (2) partial hospitalization or, if you prefer, transitional care, including

*Dr. Aldrich is Chairman of Psychiatry at the College of Medicine and Dentistry of New Jersey—New Jersey Medical School. This paper is adapted from a talk given, by invitation, at the June 7, 1971, meeting of the Mental Health Association of Essex County.

day and night hospitals; (3) emergency care and swift crisis intervention; (4) outpatient care; and (5) consultation and education services available to the community.

Behind these services lie the five fundamental concepts of catchment, coverage, continuity, community participation, and prevention. The *catchment* concept establishes a service area for which each CMHC is responsible: an area including a population of not less than 75,000 and not more than 200,000 people. The *coverage* concept requires the CMHC to care for all of the emotionally disturbed people in its catchment—not just those with acute, recoverable depressions or neurotic episodes, but the chronically ill, the alcoholics, the addicts, the defectives, the seniles, and those in the hands of civilian authorities. No one should be categorically excluded because his diagnostic label doesn't fit. The concept of *continuity* requires a smooth and uninterrupted flow of care by the same team. The concept of *community participation* insists on participation by community leaders as well as by academic or professional leaders in planning and organizing services, in an effort to insure services that are "relevant" to the community's needs. The final concept, *prevention,* includes the Child Guidance Clinic assumption that education can prevent mental illness from developing, and early treatment can prevent minor illnesses from becoming severe. It also includes rehabilitation, prevention in the sense of preventing relapse. And it includes prevention in the sense that reduction in social conditions like poverty and bigotry should reduce their associated mental illness.

To realize these promises, priorities are required, since almost 2,000 CMHC's would be needed to service a nation of 200 million people. In New Jersey, Area 4 in the center of Newark was granted a high priority; the College of Medicine and Dentistry of New Jersey undertook to plan, build, and operate the Center, assisted by Prospect House and the Youth Development Clinic of Newark; and federal construction and staffing grants were awarded, supplemented in each case by State funding. The way seemed clear to establish a model CMHC.

But along with the promising blueprint came some problems, problems shared by many of the currently operating CMHC's, particularly in high priority urban areas. These problems can be grouped in the same conceptual categories as the promises: catchment, coverage, continuity, community participation, and prevention. The *catchment* problem rises from the fact that few of the catchment areas are well-defined communities with natural boundaries and adequate internal transportation. Newark, for example, includes one complete catchment area and parts of two others. Under federal guidelines, all of Newark cannot be put in the same catchment area, but any division results in artificial "communities" without cohesiveness or adequate internal public transportation.

The *coverage* problem is even more difficult. The frontiers of "mental illness" are less clear now than in the past; homosexuality, marital maladjustment, and school truancy are examples of conditions, whose inclusion in the category of "mental illness" is now at least debatable. But the incidence and prevalence of even generally accepted forms of mental illness are beyond the capacities and resources of any CMHC not supplemented by a network of private resources. So the Center must give priority to some types of cases over others. But how shall it draw the lines? Should it reserve inpatient space for persons with chronic mental illness who may split up the space with patients who can't be discharged, or should it concentrate on the more acutely ill, who are most likely to improve spontaneously? Should it concentrate on serving children or adults? The need for children's services is extreme, but more adults than children can be treated with the same quantity of resources. Should it concentrate on depressions, which generally respond to treatment, or on addictions, which are more troublesome to the community? Should it deploy most of its resources to treatment or to prevention? Should it concentrate on reducing "medical" causes, or should it focus on

socio-economic causes? In some settings a tug-of-war develops between professionals who want to concentrate on what they believe they can do and the community which wants action in more troublesome areas for which no effective psychiatric intervention has been demonstrated. In any case, mental health centers must establish priorities, either by plan or fortuitously, and the goal of complete coverage does not appear to be attainable.

Continuity problems can also be baffling. True continuity of care requires the same therapist to treat the patient in all phases of his illness—in emergency room, hospital, transitional care, outpatient clinic, and home care. But realizing this laudable objective is expensive in travel time and cumbersome in administration; again, the limited resources available to the CMHC force a choice of ideal continuity of care for a small fraction of those needing care, or less-than-ideal continuity for a larger proportion.

The major problem in the field of *prevention* is reliance on untested assumptions of efficacy of such allegedly preventive measures as public education in healthy mental attitudes. Crisis intervention, which appears to be truly preventive in bereavement, has been assumed to be equally effective in other types of crises. It may very well be as effective, at least in certain other crises, but the assumption without adequate documentation may have led us unrealistically to expect that intervention in any form of crisis will prevent mental illness.

Another problem in prevention arises from the impact of morale on the development of mental illness. If a family's morale is eroded because of rat-infested housing, inability to get a job, victimization by discrimination, inadequate nutrition, and other social and economic factors, does the mental health center have the duty of taking an activist position on race relations, poverty, nutrition, housing, and unemployment? How much of its resources should be committed to social action, as compared to clinical activities? Does so much emphasis on environmental, social, and institutional change mean that the individual focus may become blurred?

On the other hand, the child guidance movement, which began with such high hopes in the 1920's and 1930's has not, apparently, led to a commensurate reduction in the rate of mental illness, so that the value of child guidance as a preventive device has been challenged. This is not to question the usefulness of psychiatric clinics for children, but the evidence is that the clinic is justifiable for the help it gives the disturbed child and family at the time, and not because it will prevent psychosis ten years later.

Community participation is an important modern concept, but also brings problems. If the community is invited to participate and advise, will it consider such participation meaningless unless it is also being invited to exercise control? Does community participation in mental health issues extend to related but not intrinsic issues like crime prevention, housing needs, nutritional deficiencies, and the like? The problems of the city are, typically, so great and so overwhelming that mental health services alone are not going to solve them, and there is some risk that setting up a psychiatric center may make community leaders feel that the problems are being adequately cared for.

As it now stands, the community mental health centers have, by and large, been unable to live up to the ambitious goals that have been set for them. With our personnel and financial resources strained as they are, there seems to be no immediate likelihood that the centers can be sufficiently expanded to make good on the promises. It is necessary, therefore, to scale down the promises to realistic levels. We need to make some changes: to provide greater flexibility in the definition of catchment areas, to aim at less ambitious coverage goals, to promote better participation among community agencies and collaboration instead of competition between the

community and the center, to stimulate the prosecution of research in prevention, and to encourage—by better funding—professional people to work in low income areas.

Citizens, particularly such influential citizens as the nation's physicians, can do something to meet these needs. They can extend their efforts to educate the public in mental health matters; they can inform members of the Congress of their views on the importance of increasing the funding for the training and research needed to keep mental health activities in high gear. Here in New Jersey, they can make their views known to State officials about the proposed reformation of our State's mental health agencies. They can help community mental health centers in recruitment, in developing good will, in communication, in promoting centers in areas that need them but don't have them, and in exerting the power of an aroused, well-informed citizenry toward better prevention and care of the mentally ill.

100 Bergen Street

Proposed Uniform Alcohol Act

Secretary of Health, Education, and Welfare Richardson has announced HEW's endorsement of the "Uniform Alcoholism and Intoxication Treatment Act" developed by the National Conference of Commissioners on Uniform State Laws. This, if passed, would make it a State policy that alcoholics and intoxicated persons may *not* be subjected to criminal prosecution because of their consumption of alcoholic beverages. It would require that such individuals be provided treatment for their alcohol problems.

Secretary Richardson has explained that this prototype legislation is evidence of a breakthrough in the recognition of alcoholism and public intoxication as health issues, not criminal behavior.

In most states, public intoxication is a crime, and nationally it accounts for one-third of all arrests and one-half of all persons in jail in the United States each year. "The ineffectiveness of the current laws has been clearly demonstrated in high recidivism rates and by the widespread failure to meet emergency treatment needs and provide medical and social services for alcoholic individuals."

The proposed act stipulates that a Division of Alcoholism be established within the state health or mental health department to take responsibility for making services available to alcoholic persons. Under this act, individuals would receive necessary emergency medical treatment and follow-up care involving medical, psychological, and social services rather than be detained on criminal charges.

Secretary Richardson has sent letters to the governors of all states urging them to ask their legislatures to adopt the act. Enactment of this legislation would not change the state's laws pertaining to driving under the influence of alcohol. Civil commitment of alcoholics, in common use in many states today, would be permissible in only a limited number of cases and only as a last resort in emergency situations. Further, in accordance with the act's preference for voluntary treatment, grounds for involuntary commitment would be very limited and strict procedural safeguards provided.



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Warnings: *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, than gradually withdraw. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between meprobamate, alcohol, and other CNS depressants or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. Animal data at five times the maximum recommended human dose show reduction in litter size due to resorption. Meprobamate appears in umbilical cord blood at or near maternal plasma levels, and in breast milk at levels 2-4 times that of maternal plasma. *Children Under Six:* Drug not recommended.

Precautions: To avoid oversedation, use lowest effective dose, particularly in elderly and/or debilitated patients. Consider possibility of suicide attempts; dispense least amount of drug feasible at any one time. To avoid excess accumulation, use caution in patients with compromised liver or kidney function. Meprobamate may precipitate seizures in epileptics.

Adverse Reactions: *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.

Usual Adult Dosage: 1200 to 1600 mg daily, in three or four divided doses; doses above 2400 mg daily not recommended.

Overdosage: Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

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Emergency care in Vietnam has offered lessons that can be applied to emergency care in the continental United States.

The Prevention of Death After Injuries*

William T. Fitts, Jr., M.D./Philadelphia

In the treatment of accidental injury the gap between what *can* be done and what *is* being done is wider than for any other disease. What *can* be done is shown by the record of our armed forces in Vietnam. Because of rapid evacuation by helicopter many more severely injured patients are living long enough to reach the hospital—yet the resulting mortality rate is the lowest we have ever known. Such care is not being provided for many in this country. We know we have the people and the facilities. The problem is one of *provision:* to get the injured patient to the right people and the right facilities at the right time.

Many will not recognize the magnitude of the trauma problem. *Accidental Death and Disability: The Neglected Disease of Modern Society,*[1] published in 1966 put it in clear perspective. That it continues to grow is worth emphasizing, however. In 1969, 115,000 died in this country from accidents.[2]

Although deaths from accidents rank fourth —behind heart disease, cancer, and stroke— the number of productive years eliminated by trauma raises it to third place of the killers, very close to cancer.[3] This is so because trauma is the prime killer of the young. Almost half of those killed from accidents are below the age of 35, and of the total number of deaths from ages 1 to 35, accidents account for almost half.[4] These figures concern *death* only. If disability and cost are added the total loss is indeed staggering.[2] Each year over 500,000,000 days of restricted activity are the result of accidental injury. This is nearly 20 per cent of the restricted activity from all medical causes. Hospital admissions caused by injury result in the utilization of over 22,000,000 hospital-bed days. It is the leading cause of all bed utilization in general hospitals. The tangible economic loss expressed as costs and expenses from accidents is estimated by the National Safety Council to be over $22,000,000,000 a year. Truly the loss in life, limb, and money from accidents in this country is staggering. How can the loss be cut?

If the treatment of the injured in this country is deficient, does the deficiency lie chiefly in emergency care and transportation (Phase I) or in the hospital (Phase II)? In my opinion both are sick. To support this statement let me cite four recent studies in this country.

1. Frey, Huelke, and Gikas,[5] reported 159 deaths from automobile accidents in one county in Michigan. Complete autopsies were done on all victims, and the anatomy of the accident was studied in detail. Twenty-eight of these deaths were felt to be salvageable. and *all but two* occurred in Phase I. Their prevention would have required better resuscitation and transportation. Salvage in almost all would have been accomplished by an adequate airway, intravenous fluids, and the insertion of chest tubes.

All of the salvageable deaths occurred in Phase I (emergency care and resuscitation). This is explained

*This was the Annual Trauma Oration of the American College of Surgeons (New Jersey Chapter), delivered on May 15, 1971 during the 205th Annual Meeting of The Medical Society of New Jersey, Atlantic City. Dr. Fitts is Professor of Surgery at the University of Pennsylvania and editor of *The Journal of Trauma.*

by certain factors in this study. Many accidents were in rural areas, long distances from hospitals; 30 miles or more for 30 patients. Almost all went to only three hospitals, all with good Emergency Departments and staffs, where one would expect expert hospital care for the injured.

2. Another study indicates that many preventable deaths occur in Phase I. Waller[6] found that a disproportionate number of deaths from injury are in rural areas, due to lack of good transportation and the ready availability of good hospitals. Mortality from motor vehicle accidents was higher in rural and mountain counties in California than in urban counties. The National Safety Council reports that 70 per cent of the motor vehicle deaths occurred in communities with populations under 2500. Thus, if deaths in Phase I are to be diminished, there is a special need for rural areas.

3. But all is not well in our cities either. A study that we did in Philadelphia[10] showed that the chief deficiencies in this urban setting lay in hospitals. We analyzed 950 deaths from injuries and classified 51 as salvageable. Of these, all but two died because of errors made at the hospital. Chief among these were: (1) failure to maintain an adequate blood volume; (2) errors in diagnosis; and (3) failure to provide specialized care early enough. Transportation of the victims was usually rapid. Since almost all were taken to the *nearest* of 41 hospitals, many were treated in hospitals that had less than ideal facilities or availability of staff. Examples of clearly preventable deaths were:

(a) Patients with fractures of the pelvis with retroperitoneal hemorrhage who were not given enough blood because of lack of an adequate blood bank.

(b) Patients with a ruptured spleen or liver who died of hemorrhage because of missed diagnoses or insufficient blood.

(c) Deaths from tetanus due to lack of debridement of wounds and proper tetanus prophylaxis.

4. A Baltimore study by Baker, Gertner, Rutherford, *et al*,[5] confirms our finding that in an urban setting most preventable deaths from injuries occur in Phase II—within the hospital. This was a study of deaths from automobile accidents in which complete autopsies showed that an intra-abdominal injury was a prime cause of death. The hospital records were completely analyzed and a judgment was made that *one-half* could have been saved by prompt diagnosis and treatment. More than one-third died because inadequate treatment was given for shock. In almost one-half, the patients were either not operated on, or the delay before operation was excessive, despite symptoms demanding operation. There was a disproportionately large number of deaths in x-ray departments, at night, and in hospitals not adequately staffed or equipped to care for the severely injured or critically ill.

Prevention of Deaths in Phase I

Because of the recognized shortage of physicians for all categories, I believe the personnel for Phase I should come from superbly trained auxiliary medical personnel.

Emergency Medical Technician (EMT) is the term used to designate auxiliary medical personnel trained in the care of injuries and medical emergencies. Great plans are being made for the role these men will play in medical emergencies this decade. The EMT will have the ability to work in the hospital as well as in resuscitation ambulances and in helicopters. Ideally, he should be able to perform endotracheal intubation, insert chest tubes, start intravenous infusions, and perform cardiopulmonary resuscitation. He must be given legal protection for the skillful performance of these procedures.

Some government and medical organizations in the United States have long recognized the need for the better training of ambulance personnel. This includes the American College of Surgeons. The Highway Safety Act of 1966 has provided new impetus and an opportunity for funding. Under provisions of this Act the Highway Safety Bureau published Highway Safety Program Standard No. 11, Emergency Medical Services, which recommends that all ambulances be equipped with certain lifesaving equipment and manned by at least two persons trained in specified areas of emergency care. Minimum standards have been spelled out.

A common basic training course has been made the first step to increase the professionalism of ambulance personnel. Improved training should elevate their status and justify increased pay scales, now extremely low for such highly skilled services. Corpsmen from the military should find a career as an EMT attractive after separation from the service. About 35,000 medically trained and experienced allied health personnel leave the Armed Forces each year.[9] Many enter civilian health careers; yet up to now their utilization has been minimal. To increase their flow to civilian health jobs, the Departments of Defense and Health, Education, and Welfare have set up a program called MEDIHC—Military Experience Directed into Health Careers.

A text on emergency medical care, prepared by the Committee on Injuries of the American

Academy of Orthopedic Surgeons (in cooperation with the American College of Surgeons) has been selected as the basic reference for these courses. This text, *Emergency Care and Transportation of the Sick and Injured,* consists of 59 chapters and was published in 1971. It is available for $4.95 from the Academy of Orthopedic Surgeons. Furthermore, a National Registry of Emergency Medical Technicians—Ambulance has been established with the cooperation of the American Medical Association. Its directors are representatives of six national organizations whose members are now providing emergency ambulance services, and four physicians.

Can better training of EMT's save lives? A project initiated by the Nevada Committee[10] on Trauma of the College suggests that it can. Nevada had been reported as the state with the highest death rate from automobile accidents. In 1966, 14 injured persons died in that state while in transport and 15 died in transport in 1967. After the program of training began, only four died in 1968 and four in 1969.

Instruction of Emergency Medical Technicians is the responsibility of physicians. Although lay instructors may be necessary under certain circumstances, standards must be set by the medical profession.

The use of *helicopters* for transportation of the injured has been successful in Korea and Vietnam, with the average time between injury and admission being about three hours in Korea, and less than an hour and a half in Vietnam.

The exact value of helicopters under civilian conditions has not been determined. Their use is now being tested in several areas. In Southwest Texas, Project MAST (Military Assistance to Safety and Traffic) is an attempt to apply to civilian situations the rapid helicopter evacuation technics learned on the battlefield. Sponsored jointly by the Departments of Transportation and Defense, MAST provides crews and helicopters for highway accidents, emergency medical supplies (including coral snake anti-venom), and for removing patients from small remote hospitals to facilities better able to render life-saving care. MAST was initiated in 1970 as a six-month pilot program. Hopefully, it will serve as a model for similar operations in other communities. Last year, Roberts[11] reported on the use of helicopters in the central Ohio area. A total of 50 patients were evacuated by "Medicopter" to the University Hospital in Columbus, Ohio during a two and one-half year period. Twenty-four of the twenty-five (96 per cent) evacuated directly from the accident scene survived. Thirteen of twenty-five patients (52 per cent) transferred by "Medicopter" from community hospitals survived. Six of thirteen patients who would potentially have been dead on arrival by the usual means of transfer survived to leave the hospital. Two patients with spinal cord trauma had reduced morbidity.

Prevention of Deaths in Phase II

The standards for classifications of emergency services will serve as a guide to individual hospitals to provide the facilities and manpower needed to conform to their position in the community. Guidelines have been developed by 50 physicians and government representatives. The AMA's Commission on Emergency Medical Services has suggested outlines for standardizing the categorization of hospital emergency centers according to their professional and allied health staffs and their facilities for specialized services. The four major types of hospitals thus classified are: comprehensive emergency medical center, major emergency medical center, general emergency treatment hospital, and resuscitation and emergency treatment hospital. Information on the emergency categories will be released regionally to community councils, ambulance services, and other concerned groups. When this is done emergency crews will know which hospitals have the facilities to care for each individual patient. This would allow a severely injured patient to be taken to the hospital best equipped to man-

age him, and allow the hospital to be forewarned of his arrival by communication between resuscitation ambulance and the hospital.

Classification of hospitals into four types must not depend on the Emergency Department alone, but on the over-all capability of the hospital and its staff.

Some authorities, chiefly outside the United States, believe that the care of the injured patient is best done in a specialized trauma hospital, by a traumatologist capable of treating injuries to many systems. Böhler[12] of Austria, in a recent symposium on organization for trauma care, described the Austrian system. The network of *trauma hospitals* in Austria already comprises a total of about 2,000 beds. In these hospitals traumatologists care for all injured patients. One doctor is in full charge of the patient. He is usually capable of the initial care of *all* injured systems. If a surgical specialist is needed on occasion, he is called to the trauma hospital. Böhler[12] stated that the results of this specialized organization have been spectacular. Whereas, the number of injured persons is slowly increasing, the number of deaths from trauma is decreasing slowly and the number with permanent disability is decreasing rapidly.

Most authorities in this country believe that the injured patient is best cared for in a *general* hospital on a special trauma service, staffed by a team of specialists, with a clearly defined team captain with full responsibility. The injured patient is the focus, and the necessary specialists are brought to him. Yet there is a glaring deficiency in the team approach as currently practiced. Too often, the patient is divided into systems, and each specialist assumes the responsibility for his organ only and not for the patient as a whole. When this happens, the patient may get excellent care for his facial deformities and a perfect reduction of his fractured ankle, but die of a ruptured spleen or a hemopneumothorax. For an injured patient, the team is only as good as the coordination of its individual units.

That the existing organization of hospital personnel for care of the injured and other emergencies is not ideal may be indicated by the recent formation of three new organizations:

The American College of Emergency Physicians was chartered in 1968. Its members describe a new specialty: emergency medicine. They state that this specialty has evolved primarily because an ever-increasing number of patients are seeking professional service in hospital emergency departments. Reasons cited are: the growth in population and mobility, the increased incidence of trauma, and a general decline in the number of practicing physicians accepting new patients. The ACEP is growing rapidly. According to its January 1971 report, members number 1373 and represent 49 states.

When we realize that only about 20 per cent of our general hospitals have available interns or residents they can assign for duty in the emergency department, the need for some new plan is obvious. Rotation of the attending staff has usually not proved satisfactory and the failure of this approach has fostered the growth of the fulltime emergency physician.

Some have expressed the fear that the fulltime emergency physician may result in an inferior or second grade physician in the extent of his training. Those interested in trauma need to aim particularly for completely trained emergency service coverage. Quality of care must be the first consideration. At the same time we must protect the young graduate from making any move which may narrow his opportunities and usefulness throughout the rest of his life, since this type of emergency care is considered a permanent, not a temporary profession.

Since hospital emergency departments have become the general practice headquarters for communities at nights and on weekends, all

medical problems are funneled here, emergency and non-emergency. Can one man be trained to handle all of these problems expertly? Is this not again saying that we can train one man in all specialties? Is emergency medicine a true discipline which should have a separate department in our schools of medicine? Although this system is growing and obviously filling a need, is it the ideal way to provide emergency health care? These questions need answers now, and a committee of the American National Red Cross is studying them.

The University Association for Emergency Medical Services was developed in 1969 when six young university emergency department directors met to discuss their common problems. They felt the need for an organization concerned with planning and delivery of emergency medical services, especially in universities. At an organizational meeting[13] the attendance of 138 individuals representing 96 of 119 medical schools in the United States and Canada showed great interest in such an organization. The charter meeting in 1970 was highly successful and their first annual meeting was held in 1971.

The University Association for Emergency Medical Services is composed of university surgeons, anesthesiologists, and internists. The organizers feel that these activities are not receiving adequate academic recognition, and that the university emergency department director has need of assistance in establishing the academic basis for his activities. The University Association for Emergency Medical Services is attempting to complement rather than to compete with other groups having similar aims.

The American Society for Critical Care Medicine developed from a conference group on critical care medicine which met in 1970 under the chairmanship of Dr. Max H. Weil. The members include surgeons, internists, and anesthesiologists. At the conference, leaders in the field recognized the formidable organizational problems that have evolved from the segmentation of critical care services. They stress the important role of nursing and paramedical staff and urge a close liaison with engineering, computer technology, and related technical resources. Uniform agreement was expressed on the advantages of a formally based interdisciplinary approach to the treatment of the critically ill. The formidable problems of training directors for critical care facilities were recognized. Young physicians entering this field from various specialties fear the loss of traditional identification and potential isolation that might stem therefrom in their continuing relationship with other colleagues.

The nurse is a vital part of the emergency team. Often she (or he) may be the only person on the scene. The nurse's decisions must be rapid and she must be well trained. Many nurses are attracted to this work, and we must take the initiative in organizing training courses for them. We must not teach nursing care, but rather medical care that nurses can perform. That nurses are interested is evidenced by the experience of the Chicago Committee on Trauma over the last four years.[14] Their courses began in 1967 and have been received with increasing enthusiasm. The first, one and one-half days in length, was attended by over 200 registered nurses. The third was attended by over 1,000 nurses from 43 states and two foreign countries, and lasted three days. The material presented at these courses is at the level of the third year of medical school, but the nurses have requested intensification of the curriculum.

The Emergency Department Nurses Association[15] (EDNA) was incorporated in 1970. For its symbol it chose the roadrunner. EDNA is an important step forward in the care of critically injured and ill patients. Physicians in charge of emergency departments want top caliber nurses in their departments, and must train them thoroughly. From the initial response to the formation of EDNA, it appears that many nurses are interested in this type of work.

Communications

Allow me to assess the continuing education of physicians in the field of trauma by reference to *The Journal of Trauma*, sponsored by The American Association for the Surgery of Trauma. I have been associated with it since its inception ten years ago, and in 1969, succeeded Dr. Rudolf J. Noer as its editor. Dr. Noer, beginning under less than ideal circumstances, developed the *Journal* into a viable, growing agent. The experience of the *Journal* may be a gauge of the level of interest of the surgeons of this country in trauma.

Prevention of Injuries

Up to now I have said little about the *prevention* of accidents. Yet the swiftest results could probably be obtained by prevention. The use of seat belts, championed early by the Committee on Trauma, has proved that many deaths can be prevented by safety measures. Physicians can help most in the prevention of accidents by providing expert knowledge for lay groups such as the National Safety Council and the newly formed American Trauma Society and by promoting safety measures through research, education, and legislation. I hope each of you will support the American Trauma Society and will help to interest citizens in its support. This Society gives us an opportunity to interest the laymen in his own health problems—in this instance a problem where knowledge will give him an unusual opportunity to help himself and his fellow man, since he, and not the physician, will almost always be the first on the scene of an accident.

Much needs to be accomplished toward accident prevention in relation to alcohol and drugs. Little research exists concerning the effects of drugs on driving and accidents. With alcohol, the statistics are staggering. The drunken driver has been called Public Enemy Number One, and drinking, according to the National Safety Council, is known to be a factor in half of the fatal automobile accidents. One such death occurs every eighteen minutes, amounting to 28,700 deaths per year.[2]

The Synthesis

If I have presented my case well, you should agree with me that trauma is a subject of great interest to many groups at the present time. However, cooperation and coordination are lacking. We see big wheels and little wheels, all revolving in different directions and on different axes. We need axles and a common direction to make our wagon go. Responsibility and authority must be clearly defined at the community level, as well as at the national level.

Superb care for the wounded is being provided in Vietnam, so we know that it can be done in the United States. Centralization of authority could be accomplished by the establishment of a Presidential Commission on Emergency Medical Services as suggested by the Airlie Conference,[16] or by a group of the National Academy of Sciences. The tools are available. Enough men and women for the job are in our population, but they must be recruited and trained. Enough organizations are interested. Coordination, cooperation, and leadership are needed.

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Artificial and Transplanted Organs

The first successful transplantation of an internal organ—a kidney—took place more than a dozen years ago. Today the transplantation of internal organs is still a highly experimental procedure but results have greatly improved. The transfer of some organs, notably the kidney, has become a relatively reliable clinical procedure.

According to the Transplant Registry of the American College of Surgeons, there have been 7,581 kidney transplants attempted throughout the world, from 1953 to November 1, 1971. There are approximately 3,000 reported survivors. One recipient who received a kidney from an identical twin has survived 16 years after transplant.

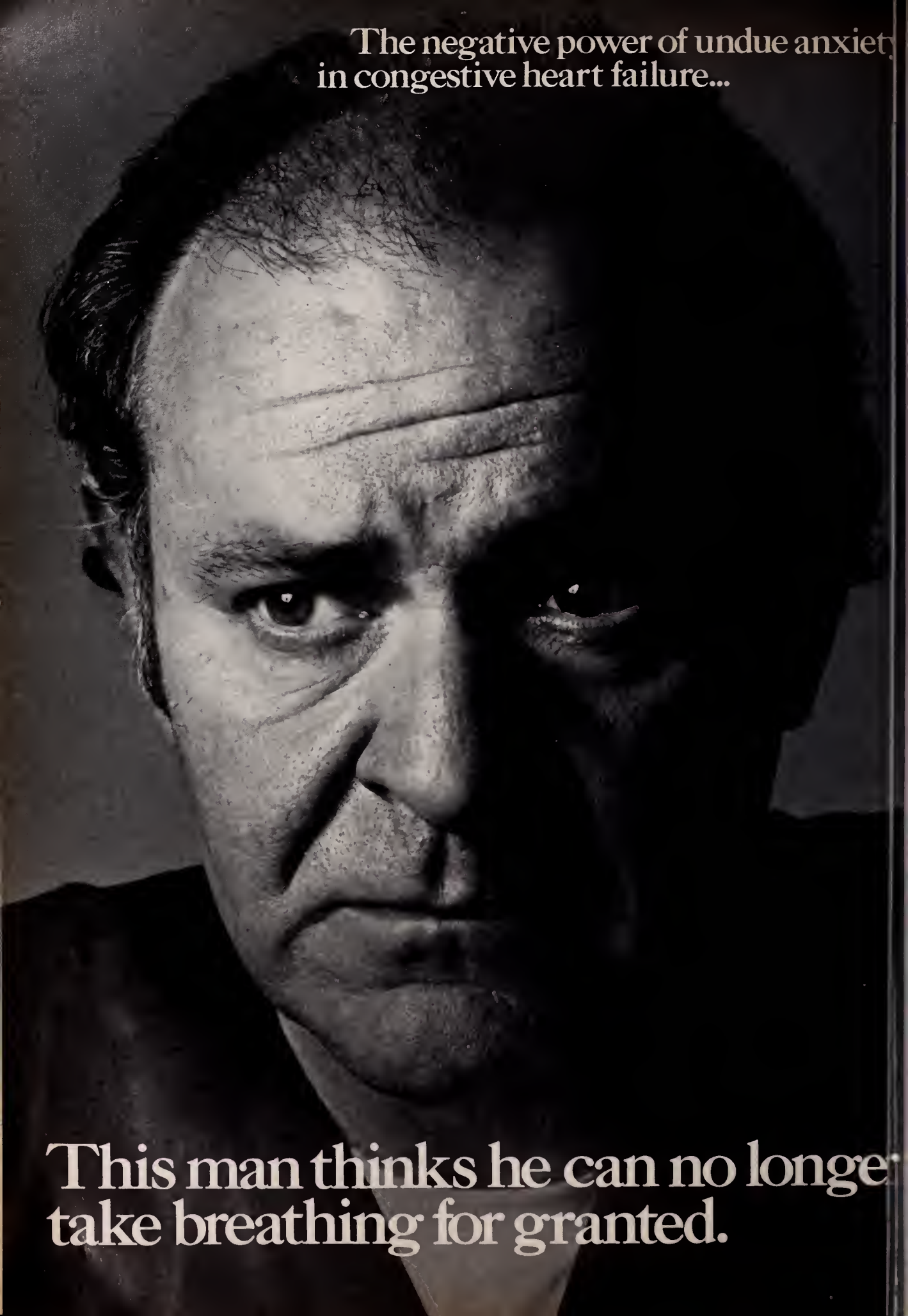
Twenty-eight heart transplant recipients are currently alive, nine having survived three years or longer after surgery. There has been a great decline in the number of heart transplants performed since 1968. In that year 101 were performed in all countries; in 1970 the figure was 17. This has been attributed partly to disappointment with the results, and partly to the recently expanded technics in direct coronary artery surgery. Two such methods are the coronary endarterectomy, in which blockages are removed from the vessel leading to the heart; the other is coronary artery bypass, in which a vein from the leg is used to bypass a blockage in the heart's blood vessels.

Many other organs have also been transplanted with varying success: liver, lung and heart; pancreas; ovary; and bone marrow.

Increasing success is in large part due to better understanding of the immunologic processes by which the human body rejects foreign tissue. A battery of drugs is now available to suppress the immunologic attack which the recipient's body mounts against a transplant.

Work is now proceeding on the development of an artificial pancreas for diabetics that would secrete insulin. A new type of heart pump has been devised by Dr. Adrian Kantrowitz with an inner coating less likely to trigger blood-clotting problems that plagued earlier implants. It is made of silicone rubber and termed a "patch booster."

An innovation in electronic heart pacemakers is the result of the efforts of a Columbia University engineer and a team of Israeli researchers. Its nickel-cadmium batteries can be recharged by transmitting radio frequency power through the patient's skin. A biogalvanic cell that generates enough power to operate a pacemaker is undergoing animal tests in Philadelphia. Current non-rechargeable models depend on mercury cells that must be replaced by a surgical operation, exposing the patient to added risk.


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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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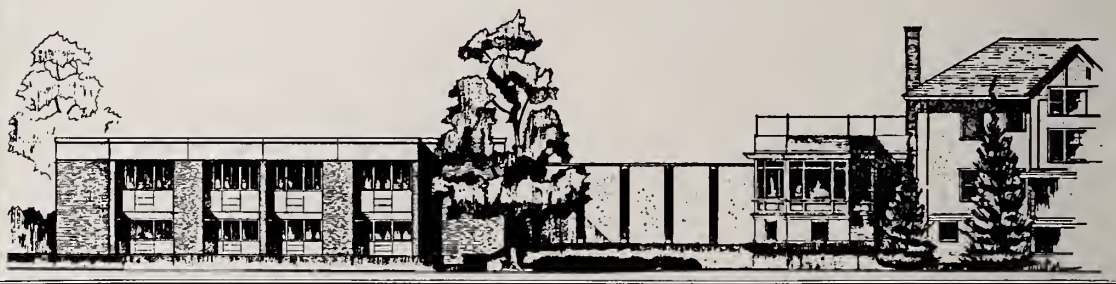
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The usual causes of megaloblastic anemia include impaired absorption of Vitamin B-12 or of folic acid. Generally the hepatic stores of Vitamin B-12 are adequate for several years, even following total gastrectomy. Malabsorption syndromes are more likely to result in folic acid deficiency.

A case of extremely severe megaloblastic anemia was encountered in a patient whose diet, surprisingly, contained large amounts of folic acid but was grossly deficient in other elements, particularly proteins.

A 23-year old woman was admitted to the Middlesex General hospital with profound weakness, mental confusion, and restlessness. She was extremely pale. Blood count revealed her hemoglobin to be 2.3 grams and her hematocrit 6.5. Red blood cells on the smear included many macrocytes and microcytes, pencil forms and teardrop forms, and much rouleau formation. Leukocyte count was 4,400 with 73 per cent lymphocytes and 27 per cent neutrophils, many of which were hypersegmented. Reticulocyte count was 1 per cent. Platelet count was greatly reduced (2,000). Hemorrhages were seen in the fundi and the urine contained large numbers of red blood cells. There were many red blood cells in the cerebrospinal fluid.

During the past six years she had been admitted to this hospital for pyelocystitis, dysmenorrhea, chronic cervicitis, and pelvic inflammatory disease. On a few of these occasions she had mild anemia for which no cause was ascertained. Tests for sickling were repeatedly negative. She was delivered of a healthy baby 2½ years before admission. Before delivery she was found to have hemoglobin 9, hematocrit 28. The hemoglobin dropped to 7, the hematocrit to 21 following cesarean section. She was transfused and given iron tablets.

From that time on she began to gain weight rapidly. Five months before her latest admission she weighed 240 pounds. She decided to follow a starvation diet and took only small amounts of solid food, chiefly raw vegetables and fruits. She drank only water and fruit juices. During the ensuing months she lost a hundred pounds and grew increasingly weaker. One week before admission she became acutely ill with headache, nausea, fever, and generalized weakness. On the day before admission she developed diarrhea and had a fainting spell.

On admission, she was disoriented and confused. There was a rough pansystolic murmur at the base. The liver edge was felt one fingerbreadth below the costal margin. The spleen was not palpable. The deep reflexes were barely obtainable but there was no sensory defect. Because of her desperate condition she was transfused at once with four units of whole blood and twelve units of packed red blood cells. During the first night of hospital stay she vomited once and had two convulsive seizures, for which she was given Dilantin.® Spinal tap was completely negative. Following this episode she recovered gradually and 48 hours after admission the hemoglobin was 9.9, hematocrit 29. She now became fully conscious.

The laboratory findings, in addition to the hematologic picture described above, included the following: Serum enzymes were elevated, SGOT being 1350, SGPT 460, LDH 500, and CPK 8.8. The direct Coombs test was negative. Bone marrow examination revealed megaloblastic marrow with adequate stainable iron, decreased megakaryocytes, and vacuolization of the granulocyte series.

The patient was placed on oral folic acid, 15 milligrams a day and responded with a marked rise in reticulocyte count so that by the sixth day the reticulocyte count had risen to 6.1 per cent and by the 8th day to 10.2 per cent. Hemoglobin rose steadily and on discharge was 12. Hematocrit was 36. Platelet count rose to 296,000, and the leukocyte differential count became normal.

Serum level of Vitamin B-12 was above normal (830 picograms per milliliter.) Serum folate level was less than 2 mmcg. per milliliter. Gastric analysis revealed adequate secretion of acid. Stool examination was normal; there were no ova or parasites. Gastrointestinal X-ray was negative. The Schilling test on the fifth day following admission revealed impaired absorption of Vitamin B-12. This was restored to normal with the second-stage test (administration of Intrinsic Factor). The test was then repeated four days later and on this occasion the results were normal. The D-Xylose test was normal. Serum carotene level was low (22 mcg per cent).

Several features in this case were puzzling.

*From the Middlesex General Hospital, New Brunswick, New Jersey, where Dr. DeCeuninck was a resident in Medicine.

For example, the patient developed folic acid deficiency despite an abundant intake of foods rich in folic acid, the serum level being less than 2 mmcg (normal 5.0 to 21). Surprisingly the serum B-12 level of 830 picograms (normal 90 to 630) was accompanied by a positive Schilling test for Vitamin B-12 malabsorption. On further consideration of this patient's problem, it was considered plausible to interpret her anemia as part of a generalized disturbance in cellular function secondary to extreme protein deficiency. Although the total serum protein was 6.7 gm per cent and albumin 5 gm per cent it is entirely possible that specific types of amino-acid deficiency were present in severe enough degree to impair absorption of folate and Vitamin B-12 and in addition to impair their utilization by the tissues. When the patient was placed on a normal diet and given folic acid by mouth the malabsorption was largely overcome so that she was able thereafter to assimilate adequate amounts of these substances from a normal diet.

Summary

A case is reported in which profound megaloblastic anemia in a young woman was induced by voluntary starvation for treatment of marked obesity. The Vitamin B-12 level was above normal despite a positive Schilling test. The folic acid level was extremely low despite an unusually abundant intake of foods rich in folic acid. This paradox was best explained by the extreme degree of protein deficiency in the patient's diet.

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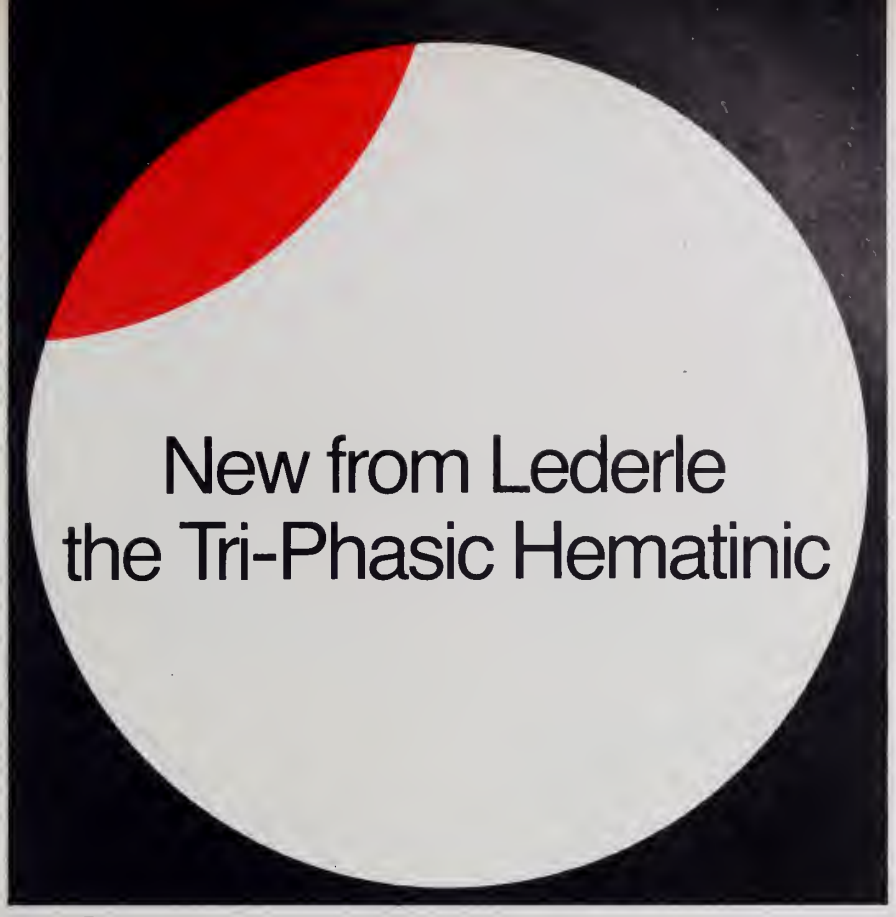
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In 1970 following the discovery of active tuberculosis in several employees on Capitol Hill in Washington, D.C., a large number of individual employees were placed on isoniazid for prophylactic purposes. Several developed jaundice. There were two deaths from hepatitis. An intensive review of isoniazid followed. Involved in this review were the National Center for Disease Control, the FDA's Advisory Committee on Anti-Infective Agents, the American Thoracic Society, and the National Tuberculosis and Respiratory Disease Association.

Available evidence could not support a conclusion that the two Capitol Hill deaths were caused by isoniazid. However, it did become evident that reports of hypersensitivity reactions such as hepatic dysfunction were more frequent than had been generally recognized. As a result of the review of isoniazid, changes have been made in the package insert. These changes have the support of the agencies identified above.

FDA urges your attention to the new "Warnings" statement in the package insert. It is evident that careful and periodic monitoring of the patient is advisable to permit earlier identification of the signs and symptoms of liver toxicity. At the first sign of hypersensitivity, including hepatitis, all drugs should be stopped. If isoniazid is reinstituted, it should be in small and gradually increasing doses to determine whether the manifestations were drug-induced. Preventive treatment for tuberculosis should be deferred in individuals with acute hepatic disease.



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Adverse Reactions: G.I.: nausea, vomiting, diarrhea, abdominal pain. Skin rashes may occur. Such reactions may necessitate temporary or permanent changes in dosage or usage. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

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421-

After the CCU, what then? Here is a follow-up of patients discharged from such units.

Acute Transmural Myocardial Infarction

Course of Illness Following Discharge from a Coronary Care Unit

William F. Haynes, Jr., M.D./Princeton

The therapeutic, diagnostic, and educational advantages of a Coronary Care Unit (CCU) are well known and well publicized. This report describes the outcome of illness in 334 successive patients with transmural acute myocardial infarction (AMI) admitted to the Princeton Hospital CCU from the first day the unit was opened on December 18, 1967 until three years later. Prime focus will be directed toward the hospital course of illness (with emphasis on mortality) following discharge from the CCU. The Princeton Hospital is a 318-bed general hospital in Princeton, New Jersey. It serves an area of about 85,000 people who come from a variety of sectors which include suburban, semirural, and a few small cities.

The Coronary Care Unit

The CCU is located in a different section of the hospital than the Intensive Care Unit (ICU) and is, therefore, not subject to the hectic atmosphere frequently found in the latter area. There are four separate rooms, each with an outside window, sliding soundproof doors, and within eyesight of the centrally-located nurses' station. Drapes can be drawn across the glass doors for emergency purposes or physical examinations. The usual bedside monitor and heart rate meter are in each room. The latter has the proper alarm mechanisms should the heart rate go below or exceed pre-determined heart rate settings. A large clock on the wall of each room starts automatically whenever an alarm goes off. "Code 45" buttons in each room (as well as at the nurses' station) lead directly to the central hospital switchboard. A memory loop is continuously recording all four monitors at the same time, and is constantly set for recording the monitor pattern for the antecedent one minute interval. The bedside alarm will start the electrocardiogram monitor strip running at the nurses' console, and it continues to run until the alarm is turned off at the patient's bedside. Routinely, monitor strips are taken every two hours on all patients and mounted on their charts.

The six house staff physicians rotate through the CCU during the year, but none are necessarily there at all times. Two R.N.'s are on duty for all shifts, and all the CC nurses have passed special courses certifying their ability to work in this specialized area. The courses are given by staff physicians about three times a year to all floor head nurses, ICU nurses, and nurse supervisors, in addition to the CCU nurses themselves. There is no formal Director of the CCU, but instead we have a CCU Committe composed of six interested physicians who formulate policies and help make any administrative decisions that arise.

Patient Population

A total of 936 patients was admitted to the CCU over the three years of this study. Of this number, 334 suffered from an unequivocal transmural AMI with typical enzyme elevations (CPK, LDH, and SGOT) as well as EKG and clinical findings compatible with this diagnosis. Patients with chest pain demonstrating equivocal EKG or laboratory

findings or subendocardial myocardial infarctions were not included in the study. The group included 83 women. The men's ages ranged from 35 to 89 years with an average of 59. The women's ages ranged from 46 to 89 years with an average of 69.

Results and Comments

As will be noted in Tables 1 and 2, 42 patients (12.5 per cent) with AMI died while in the CCU. The majority of deaths were due to pump failure (cardiogenic shock).

Twelve deaths occurred after discharge from the CCU. In other words, 22 per cent of

Table 1

Transmural AMI: In-hospital Mortality Among 334 Patients

Mortality in CCU	Mortality after CCU Discharge	Total Mortality
Males 29	Males 7	Males 36
Females 13	Females 5	Females 18
Total 42 (12.5%)	Total 12 (3.5%)	Total 54 (16%)

Table 2

Deaths in CCU

Males	Females
23 Pump failures	9 Pump failures
3 Ventricular fibrillation	1 Ruptured I.V. septum
2 Ruptured left ventricle	1 Ventricular fibrillation
1 Ruptured I.V. septum	1 Ruptured mitral leaflet
Average age: 66.8 years	1 C.V.A.
	Average age: 70.4 years

Table 3

Deaths on Medical Floors after Discharge from CCU: Patients taking Antiarrhythmic Drug Prophylaxis.

Age	Sex	Significant Past History	No. Days Since CCU Discharge Death Occurred	Antiarrhythmic Medication at Time of Death	Cause of Death Clinically	Autopsy Results
38	M	Irritable myocardium in CCU with bouts of V.T.; Hyperlipidemia, chemical diabetes; 2 prior M.I.'s; 9 days in CCU	6	Quinidine 300 mg. q 6 hrs.	Found dead in bed by lab. tech. at 7 a.m. Presumably died from lethal arrhythmia. EKG: Acute post. wall M.I.	Fresh thrombosis of R.C.A. Fresh infarction post. wall. Organized thrombus of ant. descending br. of L.C.A. and old infarct ant. wall of L.V.
73	F	Three prior M.I.s; multiple pvc's in CCU. 5 days in CCU	6	Quinidine 300 mg. q 6 hrs.	Suddenly died in bed at midnight while convalescing, presumably from lethal arrhythmia. EKG: acute ant. wall M.I.; old ant. & post. wall M.I.s	Recent occlusion of ant. descending branch of L.C.A. Fresh infarct of ant. wall & old infarcts of ant. & post. wall of L.V.
79	F	Multiple arrhythmias: pac's, pvc's. and bouts of atrial fibrillation while in CCU. 8 days in CCU	7	Quinidine 200 mg. q 6 hrs.	Died suddenly in bed after sitting in chair. EKG: Acute post. M.I. Presumably died from arrhythmia. Pulmonary embolism not ruled out.	No autopsy
84	F	Multiple arrhythmias in CCU; V. Fib., V.T., A. Fib. Cardioverted twice while in CCU. One prior M.I. 5 days in CCU	1	Quinidine 200 mg. q 6 hrs.	Sudden cardiac arrest while in bed. Probable lethal arrhythmia EKG: acute post. wall M.I.	No autopsy
70	M	Multiple pvc's & V.T. in CCU. 9 days in CCU	25	Quinidine 200 mg. q 6 hrs.	Clinical C.V.A. as cause of death rather than obvious cardiac cause. EKG: acute ant. wall M.I.	No autopsy

Table 4

Deaths on Medical Floors After Discharge from CCU: Patients Not taking Antiarrhythmic Drug Prophylaxis

Age	Sex	Significant Past History	Days after CCU Discharge Death Occurred	Cause of Death Clinically	Autopsy Results
75	M	In CCU demonstrated frequent pac's and unifocal pvc's. 6 days in CCU	12	Had frequent pvc's on floor. Unable to resuscitate. EKG: V.T., acute ant. wall M.I.	Recent thrombosis ant. desc. branch of L.C.A. Massive fresh ant. wall M.I.; old post. wall M.I.
74	M	In CCU; frequent pac's, multifocal pvc's. 13 days in CCU	12	Sudden dyspnea, rapid pulse, fall in B.P. and expired during uneventful convalescence. EKG: acute ant. wall M.I. R.B.B.B.	Fresh thrombus of ant. descending branch of L.C.A.
78	M	In CCU: freq. pac's and pvc's. During hospital stay had 2 admissions to ICU & 2 to CCLU for pain or arrhythmias. Total 6 days CCU & 9 days ICU	4	Acute pulmonary edema at midnight; possible extension of M.I.; ? arrythmia. EKG: acute anterior wall M.I.	No autopsy
79	M	Had 2 prior M.I.'s. In CCU: runs of V.T. multiple Pvc's cardioverted twice for V. Fib. Also atrial Fib. 17 days in CCU	1	Sudden V. Fib. & shock. Unable to resuscitate. EKG: old ant. M.I.; fresh acute post. M.I.	Old thrombosis ant. desc. branch of L.C.A. and left circumflex br. of L.C.A. Fresh thrombosis R.C.A.
53	M	Had 2 prior M.I.'s. In CCU: 1 bout of nodal tachycardia. Frequent pvc's. 3 days in CCU	1	Found dead in bed at 8 p.m. Presumably died from lethal arrhythmia. EKG: acute ant. wall; old post wall.	No autopsy
78	M	Was diabetic. In CCU: he had freq. pvc's & pac's. 12 days in CCU	5	Went into ventric. fib. and unable to resuscitate. EKG: acute ant. wall; old posterior wall.	No autopsy
74	M	Runs of s.v.t. and freq. pac's and pvc's in CCU 13 days in CCU	2	Sudden death in bed. EKG: acute anteroseptal	Autopsy showed recent healing myocardial infarction fresh pulmonary embolus. Thrombosis ant. desc. br. of L.C.A.

the AMI deaths occurred after leaving the CCU. Tables 3 and 4 relate to these 12 patients. As can be seen, most of these patients were in the older age group and many had had myocardial infarctions in the past. Their CCU records were examined to determine in retrospect any unfavorable prognostic signs before their discharge to the floors. As will be noted, four had one or more bouts of ventricular tachycardia requiring emergency measures. The remainder demonstrated a variety of other tachyarrhythmias, and virtually all exhibited runs of pac's or pvc's.

Although the average uncomplicated AMI patient's stay in the CCU is 4.6 days, analysis of the twelve patients in this study who died after discharge from the CCU revealed an average stay of 11.8 days, further corroborating the poor risk status of these twelve cases. Even a prolonged CCU stay does not necessarily guarantee a good outcome.

The EKG's of these twelve patients revealed seven recent anterior wall myocardial infarctions and five recent inferior wall infarctions. Tables 3 and 4 were arbitrarily divided into those taking prophylactic antiarrhythmic drugs (five cases) and those not (seven cases) to see whether the outcome of illness was influenced by these drugs.

Nine of the twelve medical floor deaths (75 per cent) occurred by the seventh day after

discharge from the CCU. Analysis of the clinical circumstances (with the aid of autopsy reports in seven cases) revealed that ten of these patients clinically died from apparent sudden cardiac arrest, most likely ventricular fibrillation. One died from a cerebral thrombosis. Another died as a result of pulmonary embolus. Five readmissions to the CCU were necessitated by either recurrence of severe chest pain or a serious arrhythmia. (Table 5)

Table 5
Readmissions to CCU

Age	Sex	Reason	Antiarrhythmic Prophylaxis on Floor
75	M	Recurrence of pain	None
55	M	Extension of A.M.I.	None
81	M	Multiple arrhythmias	Quinadine 200 mg. q. 6 hrs.
53	M	Recurrence of pain	Quinadine 200 mg. q. 6 hrs.
*78	M	Recurrence of pain	None on medical floors

*He had two readmissions to CCU and also two to ICU where monitored beds were available.

Table 6
Incidence of Overt or Chemical Diabetes in Cases Studied

Overt Diabetes		Chemical Diabetes		Total	% of Cases
M	F	M	F		
45	21	43	6	115	34.4%
*62	*69	*53	*59		

*Average age

An incidental finding of the study was the relatively high number of patients (115, or 34.4 per cent) who had the diagnoses of latent (chemical) diabetes or frank diabetes prior to their admission to the hospital. This suggests the need for more frequent standard glucose tolerance tests as part of a coronary profile work-up. AMI patients considered for glucose tolerance test should of course wait several weeks after their hospital discharge to be sure of reliable results.

In recent months, other investigators have been concerned with the number of deaths occurring on the medical floors after patients have left the CCU. Grace and Yarvote[1] found that 31 per cent of AMI patients died on the medical floors after discharge from their CCU, and Meltzer[2] noted a figure of 51 per cent at his institution.

Inasmuch as 22 per cent of deaths from AMI in Princeton Hospital occurred on the medical floors after discharge from our CCU and 75 per cent within the first week, it seems prudent to investigate the usefulness of further monitoring at least the poorer-risk patients for an additional 7 to 10 days. This is accomplished by radiotelemetry, usually in a section of the hospital adjacent to the CCU, and is referred to as an Intermediate Coronary Care Unit (ICCU).[1, 2]

Acknowledgements: Mrs. Katherine Sommers, R.N., assisted in compilation of data. The Record Room personnel located the many charts needed for this paper.

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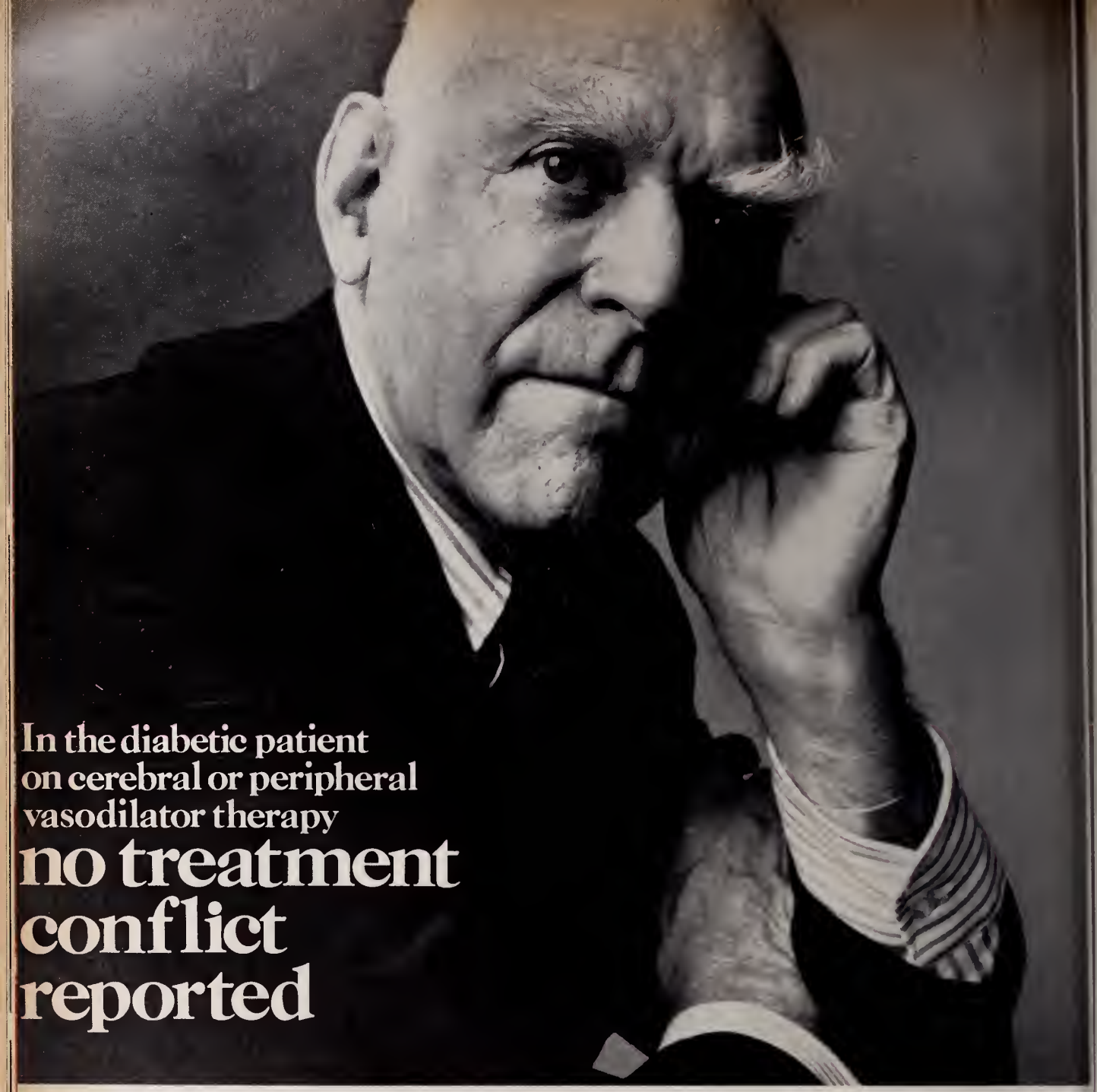
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The innocent-looking wart may be a fatal booby trap.

Surgical Approach to the Treatment of Melanoma*

William O. Wuester, M.D./Elizabeth

Our experience covers a series of 245 proved melanomas. Of these 39 had only consultation, periodic follow-up, or went elsewhere for treatment, leaving 206 who had some form of treatment by our staff. At present 85 of these patients are carried in our active file and are without demonstrable disease. Their average age was 44 years—35 were males; 50 were females. Average of this group free of disease was 85 months (7 years). By contrast, our final files contain 160 patients including the 39 in whom only consultation, etc. was done. Of those receiving private care, the average age was 43 years with equal sex distribution. Average duration until death was 45 months. Of those receiving general service care the average age was 59 years and the duration of life after diagnosis was 45 months. Most of the service group were of more advanced clinical disease so their comparable survival in months may be accounted for by the slower biologic behavior of the disease in the elderly.

Allen[2] states that the "junctional nevus—either alone, or as a part of what we choose to call a compound nevus—rather than an intradermal nevus, is the source of all melanocarcinomas of the skin and mucus membranes—the rare melanoma arising from the blue nevus is the exception." He adds that, "only a small percentage of junctional nevi become malignant" . . . That "pigmented nevi of the soles, palms, and genitalia were junctional or compound nevi furnishing a basis for understanding the vulnerability of moles in these regions to malignant change." This is of clinical importance. Routine removal of pigmented lesions in these areas would have the greatest significance toward improving the dismal end results of melanoma in these locations. *All* nevi in these locations must be regarded as precancerous until proved to be pathologically innocent. For years, pathologists differed in the origin of melanomas but are now generally agreed that the origin from the epidermal melanocyte (a normal component of freckles, nevi, and other pigmentations, and most common in nevi) is conclusive and acceptable. This recognition is of importance since the average person has about 15 moles and the early awareness of their potential by both the patient and doctor could increase the cure rate, for although melanoma may arise *de novo* by far the greatest numbers arise from nevi.

Junctional nevi are usually brown, tan, or black with variations in between. Hair is rarely present but this should not be a guiding principle especially in the presence of activity or ulceration. Any change at *any* age (especially in childhood or pregnancy) is reason for excision and pathological diagnosis. Juvenile melanoma is essentially a compound nevus, usually but not always prepubertal, showing characteristics of a melanoma with some characteristic varia-

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tions in cytological detail originally described by Sophie Spitz.[23] Grossly it tends to be hairless, larger, elevated and show early ulceration almost amelanotic if on the feet or toes. Every nevus removed for analysis should have the age of the patient, location, duration, and description for the pathologist. In questionable cases, our pathologist asks for extra opinions. There are enough metastasizing and fatal prepubital melanomas reported in the literature to be ever cautious in this detail. I personally try to review with the pathologist as many of the removed nevi as possible. It has given me a better appreciation of the whole problem.

Most lesions are underdiagnosed by the practitioner accounting for innumerable lesions removed in the office through 2 to 3 centimeter incisions which, in many cases, must lead to manipulation of the lesions and incomplete removal. On the other hand a very high index of suspicion on our part leads to over diagnosis in many cases. This is especially true in darkly pigmented lesions and in some of the early ulcerated adenoid cystic basal cell epitheliomas. When suspicion is high, the patient is admitted for general anesthesia and an excision with about one centimeter border down to the fascia with minimal manipulation. If frozen or formal section reveals melanoma, the area is re-excised with a 3 to 5 centimeter additional border including the fascia. Retracting clamps can be placed on the underlying fascia for elevation to facilitate removal of the local area. With modern skin grafting and/or sickle flaps a fairly acceptable cosmetic result can be obtained. We remove fascia where possible since we are unable accurately to estimate the depths of tumor extension. Clamps on the fascia and skin edges (for retraction) rather than using rake retractions on the soft tissue minimizes the possible milking of the malignant cells into the operative wound. Once the planned excision has started it is done as quickly as possible in a cephalad to caudad progression with wound coverage for protection. Of prime importance is adequate excision. Plastic repair is of secondary importance. We must admit the local wound recurrences can be noted more readily in skin grafted areas than in those patients who have had full thickness rotated flaps. I am unable to say if this makes a difference in the ultimate cure rates but women especially appreciate full thickness flap repair. A much more conservative excision is indicated in elderly patients with *Lentigo maligna* (melanotic freckle of Hutchinson) and superficial melanomas. These and the juvenile melanoma are the only three exceptions to a very wide, careful excision.

Node Dissection

Should the primary nodal area be resected at the same time in continuity with the primary lesion? Das Gupta and McNeer[9] reported that 25 per cent of patients with clinically negative nodes had histologic metastatic melanoma in the surgical specimen. Their five year survival rate for these was 53 per cent compared to 10 per cent survival when nodes were clinically positive. The crux of adequate therapy hinges on these statistics. The primary lesion and the nodes should be removed in continuity at the initial operation, affording the patient the best chance of cure. If a joint intervenes between the primary and the nodes either simultaneous resection of both areas in discontinuity or a few weeks delay before doing the node dissection, is advised. Theoretically this is to allow malignant cells in transit to be filtered to the screening nodes. We delay the node dissection in those cases where a delayed healing of the graft or flap would be anticipated with the secondary edema especially common after the radical groin procedure.

Consider the following staging chart:

Surgical Staging

Stage 1. Localized melanoma without distant or regional metastasis to lymph nodes.

a. Primary untreated melanoma or removed by excisional biopsy within one month.
b. Locally recurrent melanoma.
c. Multiple primary melanomas.

Stage 2. Metastasis confined to regional lymph nodes.

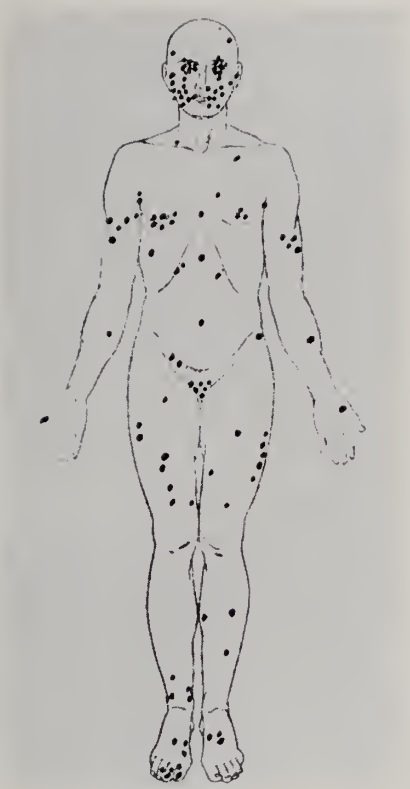


Figure 1



Figure 2

a. Primary melanoma present with simultaneous metastasis.
b. Primary melanoma controlled with subsequent metastasis.
c. Recurrent melanoma with metastasis.
d. Unknown primary with metastasis.

Stage 3. Disseminated melanoma.

a. Organic and/or multiple lymphatic metastasis.
b. Multiple cutaneous and/or subcutaneous metastasis.

This may be of aid in initial evaluation of the surgical status but melanoma is so unpredictable in its lymphatic and hematogenous metastatic manifestations that multiple changes in the staging may become necessary. A clinico-pathological classification, which should be incorporated with the surgical evaluation is suggested by Clarke[6] on the basis of gross examination and multiple histological sections. His headings are superficial spreading melanoma, nodular melanoma, and *lentigo maligna* melanoma. These are further subdivided into five grades of invasiveness. This is a guide to prognosis and we hope to follow this recent suggestion in our cases. Of importance is an accurate gross examination and evaluation and an adequate description thereof in the chart. Chest roentgenograms are routine in all patients. We have not used lymphangeograms. Ariel[3] informs me that "he has roughly a fifty per cent error." He has had negative lymphograms and at the time of groin dissection positive cells are found in the nodes. Contrarywise, he has had "enlarged deposits in the lymph nodes which were thought to be disease only to be found on removal to be replaced by fat. Indications have narrowed down tremendously since I began using it."

We have performed elective node dissection in all cases of melanoma except where the pathologist has reported very early or superficial melanoma or where the primary lesion is at a point in which it is impossible to be certain of the lymphatic spread. In these instances, the entire situation is discussed with the patient and family with properly witnessed notes on the chart, so we have a promise of cooperation in the follow-up of



Figure 3



Figure 4

the patient at stated intervals and medico-legal protection also. No difficulty has been encountered to date with this procedure. Once again the competent pathologist is the key in this situation. He must understand the problem and cooperate fully.

Scalp: With its rich lymphatic and blood supply early metastases are expected. Fortunately the neck is easily palpated for abnormal nodes. If this lesion can be encompassed with a radical neck dissection and graft we would prefer it. If such a procedure is not feasible then a delayed dissection is advised. Prognosis with scalp lesions has been poor.

Face: In lesions of the eyelids and upper cheek region wide excision with flap or graft repair is followed by a discontinuous neck dissection in individualized situations. If the primary source is near the chin or mandible area the excision can easily be combined with the radical neck dissection. It is our policy to make the skin flaps of the neck extremely thin taking all the platysma.

Neck: Here we do wide resection with radical neck resection. We have excised large amounts of skin around the primary tumor and covered the vital structures of the neck with a split thick graft.

Arms: Our choice is wide dissection and graft in continuity with the axillary dissection. We have had no difficulty in dissecting the axilla adequately and thoroughly by wrapping the lower arm in sterile drapes so that by moving it advantageously the axillary contents are more easily dissected. In this manner the pectoralis major and minor can be retracted for better exposure. In the lower arm, we recommend wide dissection, graft, and either simultaneous discontinuous radical axillary dissection or delayed dissection depending on the particular situation.

Finger: Here we prefer amputation at the base with either simultaneous or delayed axillary dissection. We have had to amputate four arms. Only one patient is alive 13 years after amputation with a negative axillary dissection. Nine years after the operation the patient developed an epitrochlear node positive on aspiration biopsy. This required the amputation. A very difficult situation confronts the surgeon when the patient appears with recurrent disease in an extremity between the primary surgical site and the nodal dissection area. If very careful screening of the patient fails to reveal any other evidence of generalized disease outside of the extremity we advise early amputation after full discussion of the problem with the patient. No other method of treatment is acceptable. The Memorial Hospital reports a 35 per cent, five year survival for the lower extremity and 25 per cent 5 year survival for the upper extremity in this grave situation. When primary disease, plus

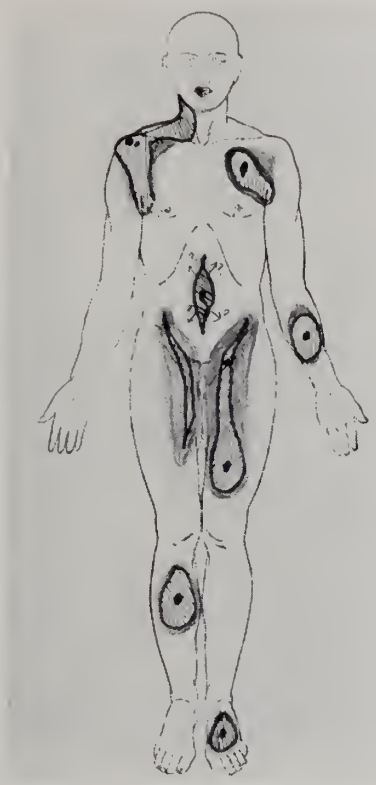


Figure 5

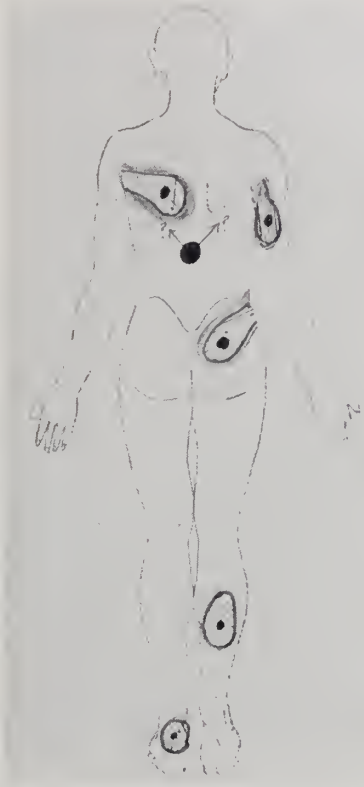


Figure 6

regional metastases, plus intervening metastases are present, an extremity radical amputation is advised only after complete screening and a negative abdominal exploration.

Lower Extremity: Here the principles governing treatment of melanoma of the upper extremity hold true. Because of the trauma of weight bearing and shoe irritation, our experience indicates those lesions in this area to have a poorer prognosis than similar lesions on the hand. A word of caution is indicated. It is discouraging to see limited local excision done for extremity lesions and then a so called "groin or axillary dissection" done through a 6 to 10 centimeter incision. This is like signing the death warrant for the patient. Radical groin dissection denotes a wide removal of the superficial nodes and subcutaneous surrounding lymphatics and a retroperitoneal removal of the pelvic nodes and lymph-bearing tissues from the bifurcation of the common iliac artery into external and internal artery to the passage of the femoral artery beneath the sartorius muscle near the apex of the femoral triangle. To facilitate this, we transect Poupart's ligament from the anterior superior spine of the ilium. Since the ureter crosses near the bifurcation of the iliacs this must be checked carefully. Just before the internal iliac passes under Poupart's ligament it gives off the deep circumflex artery running laterally and the inferior epigastric that runs anteriorly and medially along the under surface of the anterior abdominal wall. These must be carefully ligated for adequate exposure. The pelvic portion of the dissection is always done after the superficial groin dissection. We have found it difficult to keep the specimen in continuity so the superficial groin specimen is usually, but not always, removed from the operative field at the level of Poupart's ligament. To fill in the rather large defect in the femoral triangle we either shift medially or transpose the sartorius muscle either in whole or in part by splitting it. If a large segment of skin over the nodes has been removed we cover the defect and transposed

Radical Node Dissection—Three Year Postoperative Analysis

		Path +	Path —	N.E.D.	Died	Coronary Death	Satellitosis
DISCONTINUITY							
Groin	38	25 (66%)	13	24 (63%)	14	3/14	3/38
Axilla	30	19 (63%)	11	17 (57%)	13	1	
Arm Amp.	4	4		1	3		1
IN CONTINUITY							
Groin	7	5 (71%)	2	5 (71%)	2	1/7	1
Axilla	13	7 (54%)	6	10 (77%)	3		
Labia	4	2	2	2			

sartorius muscle with a 20/1000 inch split thickness graft. As with breast operative grafts, we find better healing with the graft and much skin necrosis is avoided. Constant postoperative wound suction with the hemovac has been of tremendous benefit and we no longer have the wet maceration of tissue common 10 years ago.

Back and Buttocks: Since the drainage area is the groin, a wide resection in continuity with the nodes is advised. In the upper back the same principle follows, namely resection in continuity wherever possible. The only exception is in centrally located lesions where it is impossible to tell whether the disease will metastasize either to the right or left drainage areas. In this situation careful observation at monthly intervals of draining node areas is advised and wide dissection delayed until positive clinical evidence is available.

Vulva: Because of the bilateral drainage, radical vulvectomy with complete bilateral removal of the superficial and deep nodes is advised.

Eye: Of the ten cases, eight are living and well and the postoperative average for the group is 6 years. Two died of diffuse disease at six and nine months. The procedure depends on evaluation of the extent of disease. Six of the eight living cases had enucleation. One had exenteration of all the orbital contents including the eyelids when the disease was found to extend through the sclera. Split thickness grafts heal very well in the orbit. The more radical procedure precludes the use of a glass eye. For cosmetic appearance an opaque eye glass can be worn over the area.

It is our experience that if a patient is to develop metastases this will occur in about 80 per cent within a two year period. Three-year figures are significant for after this duration of follow-up, we lengthen our interval examinations to three months. This does not mean any assurance of freedom. One of our groin patients with bilateral positive, multiple, and large metastatic nodes had her first recurrence in the local vaginal cuff area after 17 years. This only stresses the value of continuous follow-up and tumor registry work, so difficult in this day and age.

In our experience, the usual progression of inoperable melanoma has not been altered by any chemotherapeutic agent which we have used to date. Stehlin[22], after elaborate and expensive perfusion procedures, did *not* show improvement in his final end results. Recently a new drug, Imidazole Carboxamide (National Service Center—45388) has been reported as useful in some stages of melanoma—19 per cent of patients achieved objective response for 1 to 8 months with a median response of three months. Of those 21 patients, five achieved complete regression. Only time and control studies will tell the final story.

A bibliographic listing of 22 citations will be included with author's reprints.

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Primary sarcoma of the breast is rare, but not so rare that it should be forgotten.

Primary Sarcoma of the Breast

Albert J. Kolarsick, M.D./Red Bank*

In reviewing a personal series of 310 mastectomies done between 1956 and 1970, only three cases of sarcoma of the breast were encountered. One of these was a "benign" cystosarcoma phylloides in a 78-year old female. This lesion measured 2 centimeters in its greatest diameter and was treated with simple mastectomy with good results. This paper will deal with two primary malignant sarcomas of the breast, an incidence of 0.6 per cent of our 310 cases, which is twice that of 0.3 per cent reported by Ariel. Primary sarcoma of the breast is rare. Although it affects all age groups, it is most commonly found in the fourth and fifth decades. The gross appearance of sarcoma of the breast, when large, is usually diagnostic. There is a teardrop appearance of the breast with flattening of the nipple. Evidence of lobulation may be present. Areas of red-purple hue of the skin and fluctuation are frequently noted due to the liquification and cystic formation these tumors undergo. The skin is fixed to the tumor; however the entire breast is usually movable on the chest wall. Ulceration is rare. The lesion is painful due to the rapid enlargement of the breast.

Case One

A 36-year old gravida 1, para 1, was first seen in February, 1969, with the complaint of rapid enlargement of the right breast. This had occurred within a period of six weeks and had become hot and painful the last two to three days. Her past history was unremarkable with the exception of having been involved in an automobile accident in September, 1968. There was no mention of injury of the right breast at the time. The physical examination was essentially normal except for the right breast which appeared to be twice the size of the left. The skin was shiny and taut while the entire breast was warm and tender to touch. High in the right axilla there was a movable node. The left breast was entirely normal.

On March 3, 1969, a biopsy of the right breast was done. Upon incising into the upper outer quadrant of the breast, a large cavity was immediately entered. It contained a large amount of dark red clotted and liquid blood which was evacuated, along with brain-like tissue. Bleeding was brisk. Further exploration showed the tumor mass to involve the pectoralis major muscle. The tissue submitted for frozen section was reported as sarcoma. At this point the bleeding was controlled and the wound closed. A description of the microscopic examination revealed sections which showed a diffuse proliferation of connective cells with whorled and palisading arrangements, many with spindle shaped cells. Numerous multiple nucleated giant cells were seen, some with a definite foamy cytoplasm. Large nuclei were also prominent. One significant feature was the presence of osteoid formation. No epithelial cells were seen. Diffuse and focal areas of hemorrhage and extensive necrosis were noted. The diagnosis was osteogenic sarcoma of the breast.

The patient was treated with 4000r cobalt between March 5 and April 27. This did little to shrink the tumor size of the breast and she continued to have pain and serous drainage from the biopsy site. All studies, including x-rays of the lungs, skull, ribs, and upper and lower extremities were negative. On May 9, the patient underwent a right radical mastectomy with skin grafting to the right anterior chest wall. Microscopic examination again revealed osteogenic sarcoma of the breast. Lymph nodes were free of metastasis. Post operative course was uneventful and the patient was discharged on the eleventh day to be followed in the office. Except for an incidence of cellulitis of the right arm which occurred in July, 1969, the patient did well. She was seen again in December of that same year with a history of shortness of breath on exertion and an episode of hemoptysis. Chest films revealed evidence of metastatic disease in both lungs. Upon hospital admission, a course of Cytoxan therapy was administered for ten days, following which she improved and was discharged. Another episode of severe dyspnea occurred in February, 1970, and the patient was again admitted to the hospital. X-rays of the lungs showed marked extension of the metastatic process, especially in the left lung field, with atelectasis and a shift of the mediastinum and heart to the left. She was placed on Cortisone and Cytoxan. Dramatic improvement was noted and the patient was discharged home on February 10, to continue with medications and office follow up. She did well until April 17, when she was readmitted with cyanosis, dyspnea, and orthopnea. She expired almost immediately.

Case Two

A 45-year old nullipara, was first seen by her family physician in July 1970, with a three week history of rapid enlargement of the left breast associated with redness and pain. A diagnosis of mastitis was made

*Dr. Kolarsick is Director, Department of Surgery, Riverview Hospital, Red Bank, New Jersey.

and the patient was placed on antibiotic therapy for two weeks with no relief. She had been unaware of a lump in either breast; however, she stated the left breast had always been larger than the right. Physical examination was normal except for the left breast which was three times the size of the right. The skin was taut, shiny, and red. The nipple was flattened and the breast appeared lobulated. An area measuring 6 centimeters was noted outside the areola. It was red, tender, and fluctuant. The skin was fixed to the underlying breast which was movable on the chest wall. The right breast was negative and there was no axillary adenopathy on either side. The preoperative chest plate revealed a massive homogenous breast on the left side and evidence of metastatic disease in the right lung field.

On July 15, 1970, the patient underwent surgery for a left simple mastectomy with a skin graft to the anterior chest wall. Pathological examination showed that the major portion of the breast was occupied by a large mass with evidence of nipple retraction. Upon sectioning, a huge tumor measuring 15 centimeters in diameter was seen. In the center was a large cyst. The tumor mass, while not encapsulated, was sharply demarcated from normal breast tissue at the edges. The greatest portion of the tumor was soft, fleshy and white in appearance except for some areas of hemorrhage and yellow necrosis. At one edge, a smaller mass of bulging white fibrous tissue resembling a fibroadenoma, was seen. The bulging, white, fibrous tissue consisted of acellular, sclerotic fibrous tissue and remnants of atrophic, compressed breast ducts, typical of a benign sclerotic fibroadenoma. The soft, fleshy areas consisted of close-packed fibroblastic cells. Nuclei were generally elongated and showed considerable variations in size and shape. Irregular mitoses were frequent and occasional bizarre, giant nuclei were also present. Loose, myxomatous areas of sarcoma blended into the denser fibrosarcomatous areas and both types of tissue infiltrated the periphery of the sclerotic area. Ten lymph nodes removed at the time of simple mastectomy were normal.

Postoperative course was uneventful and the wound healed *per primum*. She received a course of cobalt therapy to the right lung metastasis between July 23 and August 25, 1970. The mass reduced approximately a fourth in size. The patient was seen in the office October 20, 1970, with the complaint of word aphasia; however she lacked further signs or symptoms of cerebral involvement. Breath sounds were decreased over the entire right lung field. The patient was admitted to another hospital by her family physician because of convulsions and died October 27, 1970.

Kennedy and J. D. Biggart,[2] evaluated their personal experience in the treatment of six breast sarcomas occurring in the previous ten years. In reviewing the literature between 1934 and 1966, they gathered a total of 35 sarcomas, 5,453 carcinomas and 1,189 fibroadenomas. These cases covered the population of northern Ireland (1.5 million people.) Of the 35 sarcomas, four were lymphosarcomas which presented as primary breast tumors. They excluded these from their study. Of the remaining 31 cases, 11 had their origin in fibroadenomas. They classified their cases as follows:

1. Adenosarcoma	(11 cases) There was a definite or probable origin from a fibroadenoma.
2. Carcinosarcoma	(2 cases) These cases lacked evidence signifying origin from a fibroadenoma.
3. Pure sarcoma	(18 cases) An epithelial component was lacking in these cases. Microscopic features were those of a mesenchymal proliferation. Of 18 cases, 13 were spindle cell sarcoma, 1 a myosarcoma, and the remaining 4 cases showed features indistinguishable from those usually confined to osseous tissue. One was a chondrosarcoma and the other 3 were osteogenic sarcoma containing islands of pure bone.

According to the above classification, our case number one is considered to be a pure sarcoma. Microscopically, the osseous and cartilagenous elements were dominant and readily recognizable. Remnants of breast parenchyma were infiltrated by tumor cells. Also a lack of relationship to other bones, as evidenced by normal radiological appearance of all long bones, ribs, vertebrae and skull, points to primary origin in the breast. Case number two, having presented a definite fibroadenomatous component, would be classified as an adenosarcoma, according to Kennedy and Biggart.[2]

Norris and Taylor,[3] described the clinical and pathological findings in 32 patients with mesenchymal neoplasms of the breast. These neoplasms were similar to mesenchymal tumors elsewhere in the body except that heterologous differentiation to form bone, cartilage, muscle and fat was surprisingly frequent. Recurrent lesions occurred in 12 of the 32 patients, all within 14 months of initial therapy. Eight patients died of their tumor within five years.

They state that the specialized tissue of the breast, specifically the periductal, interlobu-

lar and intralobular fibrous stroma, give rise to neoplasms that differ basically from cysto sarcoma phylloides in that an epithelial component is absent. These neoplasms of mammary stroma are similar to soft tissue tumors elsewhere in the body since they are basically spindle cell (fibroblastic) proliferations. Some of these tumors had histologic features of low grade fibrous proliferations, but they tended to recur often with a worsening histologic appearance. Metastatic capability was impossible to predict, but it was apparent that any tumor with five or more mitotic figures per ten high powered fields was capable of metastasis. Of their 32 patients, 8 contained elements of bone and/or cartilage. However, these heterologous elements, in every instance, were minor as the spindle element was dominant.

Cysto sarcoma phylloides comprises over half of all breast sarcomas. It arises from a preexisting fibroadenoma and usually occurs ten years earlier than adenocarcinoma of the breast. The tumor usually grows slowly and the patient is aware of having a small lump in the breast for years before rapid enlargement takes place. These tumors vary in size up to as much as 30 pounds. The massive size, however, does not necessarily indicate malignancy, nor does a small tumor exclude it. Four of Kennedy and Biggart's cases measured less than 3 centimeters. There is no relationship between trauma, childbirth, lactation or abcess in the development of breast sarcomas. In 1950, McDonald and Harrington[8] estimated that a sarcomatous stroma occurred in 10 per cent of all so-called cysto sarcoma phylloides.

Metastases to axillary lymph nodes is very rare. These lesions tend to spread by direct extension or via the blood stream. Lester and Stout[9] found 28 per cent of their cases to be histologically malignant. However, of these, only 2.8 per cent metastasized. Treves and Sunderland[5] reviewed 77 cases at Memorial Hospital extending over a period from 1930 to 1949. They found 9 out of 18 histologically malignant lesions to metastasize to viscera and only one to axillary lymph nodes.

Treatment and Prognosis

While small tumors of the cysto sarcoma phylloides variety may be locally excised, the better and usual treatment is simple mastectomy with removal of the pectoralis fascia and/or pectoralis muscle if involved. On rare occasions, a radical mastectomy is done for the histologically malignant variety with axillary metastasis. Skin grafting is often necessary to cover the chest wall. Radiation and chemotherapy are of no value in the treatment of this tumor.

Kennedy and Biggart[2] found it difficult to determine which of their cases would recur or metastasize. They found it easy to diagnose a tumor as malignant if it had bizarre, pleomorphic stroma, and frequent mitotic figures. But some of these stromal tumors had a very cellular, spindle-cell structure, yet, showed no pleomorphism and few mitosis. Analysis of their six fatal cases indicated that in only three cases was the incidence of pleomorphism moderate to marked, the other three being mild.

Even though our case number one died in thirteen months from diffuse bilateral pulmonary metastasis, Kennedy and Biggart's report[2] indicates that sarcomata containing bone and cartilage do not necessarily have a sinister prognosis. Three of their cases have survived nine months, nine and one-half years, and eleven years. They admitted their inability on histologic grounds to differentiate, with any certainty, a tumor which is going to assume aggressive characteristics from one that is likely to be cured from a simple mastectomy.

While the two primary sarcomata of the breast discussed in this paper are rare, there are others of even less frequent occurrence. Lymphosarcoma occasionally occurs in the breast as the only site of involvement but more frequently as part of the general disease. Extremely rare are angiosarcoma, liposarcoma, and myosarcoma.

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BNDD has estimated that large amounts of the legally produced drugs have been diverted into the illicit drug traffic.

The 40 per cent production cut was recommended by the Department of Health, Education, and Welfare. The proposed quota is the first time the government has used this authority under the Drug Abuse Prevention and Control Act. Manufacturers had 30 days to contest the action before it took effect.

Legal use of amphetamines could be curtailed as the result of a current Food and Drug Administration evaluation study of their effectiveness as a weight-reducing drug. FDA has ordered amphetamine manufacturers to submit additional proof of effectiveness.



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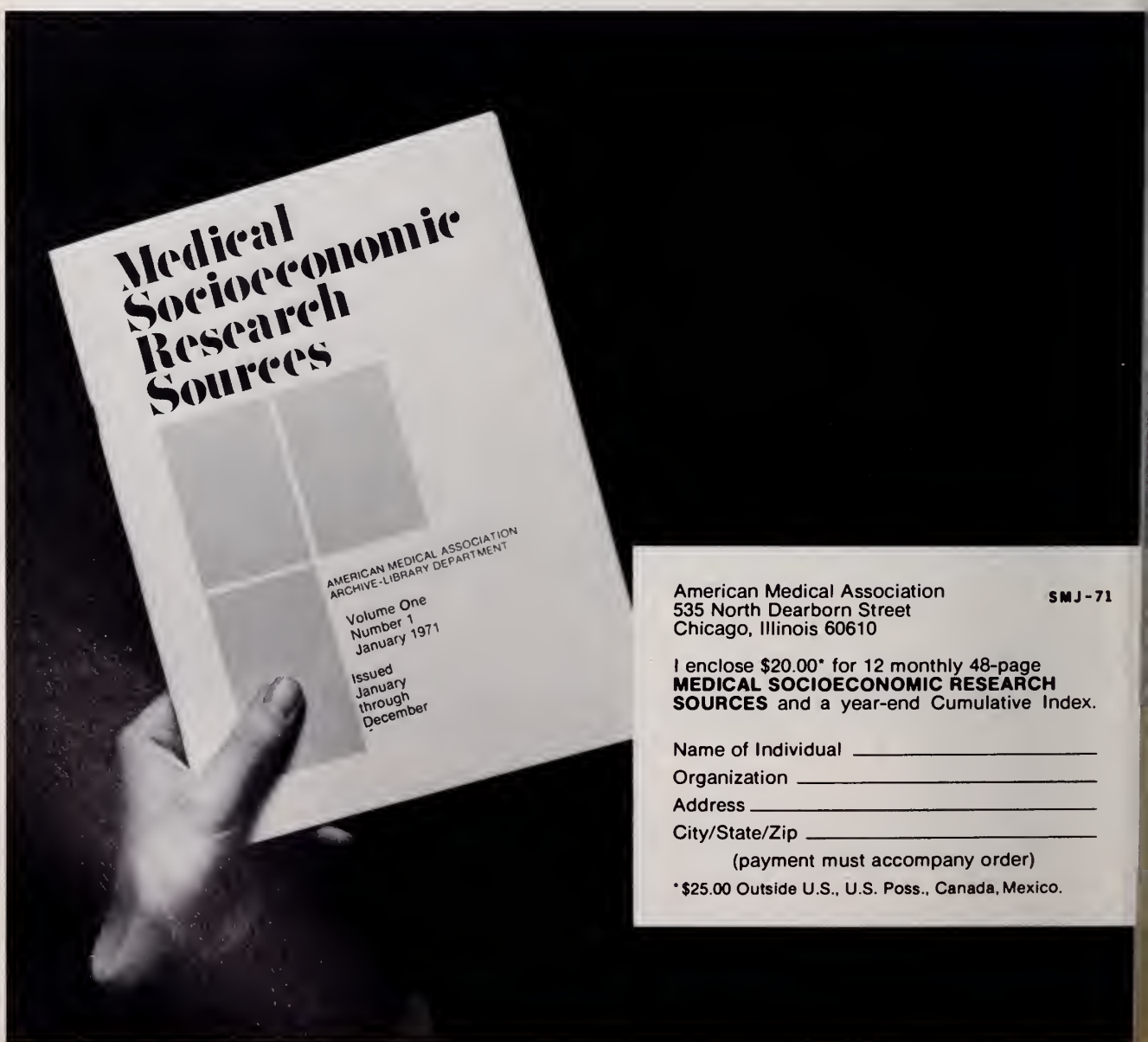
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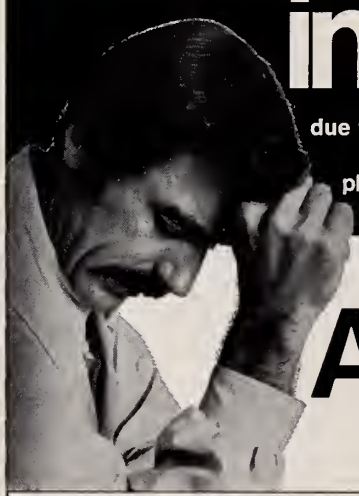
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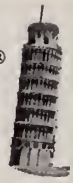


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Here are concrete suggestions on a subject that is getting increasing attention these days.

Physician Assistants' Training*

A Model for Human Resources Development

Stanley S. Bergen, Jr., M.D./Newark and Richard W. Clapp/New York

The number and variety of physician assistant programs is steadily increasing. These models provide different training methods and worksites which we can use to evaluate their effectiveness and their prospects for the future.

A few of the physician assistant programs, such as the Brooklyn-Cumberland/Long Island University Medical Services Associate program, have attempted to recruit members of minority and/or low income groups. We would like to emphasize this aspect of physician assistant recruitment. The underlying philosophy here is that there are secondary gains (beyond the obvious gains in new health manpower) in providing meaningful new jobs and a positive image of the health professions in minority and low income communities. Lenzer[1] feels that such training programs "will give role models to the poor, an underused human resource—a resource that may well prevent violence by the loss of meaninglessness of life."

Another advantage is that these people are more familiar with the attitudes and mores of the communities where they reside. Strauss[2] suggests that the health care delivered by such indigenous paraprofessionals may well be more dignified and acceptable to the patients than that delivered in the past by professionals with different backgrounds. Since dignity and accountability of the services to the needs of the community should be a goal in all our health programs, this aspect of assistant training is important.

Another significant source of physician assistants has been (and will continue to be) the returned military medical corpsman. The military services' placement programs, "Project Transition" and "Re-Med," attempt to make returning corpsmen aware of the opportunities for further training and employment in the civilian sector as physician assistants.

The curricula of the various physician assistant programs vary widely. The *ad hoc* panel of the Board on Medicine of the National Academy of Sciences has suggested[3] distinctions between three types of physician assistant, based on their training and functions. Types B and C are either highly trained in a special skill or broadly trained but requiring constant supervision. The Type A physician assistant, using his rubrics, aids the physician in diagnostic and therapeutic procedures and supervises the activities of other technicians; it is this type that we will concern ourselves with in the discussion of a model curriculum.

The goal in all health careers' training programs should be to provide a continuum of courses and clinical experience that will allow the health worker to advance to that degree of skill and responsibility of which he or she is capable. Job categories should be structured to allow the health worker to stop at a plateau that best utilizes his capabilities, with

*This was delivered, in part, January 28, 1971, at the Physicians' Assistant Conference, Brooklyn-Cumberland Medical Center, Long Island University, Brooklyn, New York. Dr. Bergen is President of the College of Medicine and Dentistry of New Jersey, and also Professor of Internal Medicine. Mr. Clapp is Executive Assistant of the New York City Health and Hospitals Corporation.

the potential of moving on to the next level when he has demonstrated motivation and ability. The curriculum must be developed as a set of building blocks, or modules, with each level providing a base for the next. Such a continuum provides the student with the prerequisites for higher achievement and hopefully eliminates much of the current dead-end training. The program should be flexible enough to accommodate the diverse backgrounds the candidates will bring to the program. High schools should give courses which provide background for careers in health. The curricula of physician assistant programs may vary widely. One possible curriculum is here outlined.

The model program could be offered as a two-year, year-round, full-time course with the academic material given at a university or community college and clinical work performed at a university medical center or community teaching hospital.

At the university, the students would be required to take a sequence of courses in the natural sciences and liberal arts; these would include English, mathematics, chemistry, biology, anatomy, physiology, microbiology, sociology, psychology, and urban studies. The courses should be spaced to run the entire two years, but the clinical work should predominate the second year.

The clinical course should be divided into three phases: (1) clinical introduction, (2) medical sciences, and (3) clinical rotations. The clinical introduction is designed as a first step in the development of a "core curriculum" for all students entering programs in the allied health field. Core curricula are being offered in many institutions in order to:

(1) familiarize the student with the diverse opportunities in the health field and thus enable him to make a wiser judgment concerning his eventual career, and

(2) insure better that the student entering the health field is exposed to a common philosophy, outlook, and language to enhance his ability to interact with fellow members of the health team.

Core course content should be developed to enable students to:

(1) gain an understanding of health service resources,

(2) gain an understanding of and experience with team relationships,

(3) become acquainted with ethics in the health field,

(4) gain knowledge of pathophysiology and psychopathology,

(5) understand how diseases are treated, and

(6) develop skills in maintaining environments conducive to patient welfare.

The second phase of clinical work should be closely coordinated with classroom work in anatomy and physiology at the university. The clinical courses, referred to as "Medical Sciences," should be presented using the integrated curriculum method.[4, 5] This method has been used with success notably at Case-Western Reserve School of Medicine[6] and also in the Purser-Pharmacist Mate Program (Marine Physician's Assistant) at the United States Public Health Service Hospital on Staten Island. The integrated curriculum method "provides a unified academic and applied (clinical) exposure to each subject, thereby enhancing the student's uptake and retention of information."[7]

The third phase of clinical work, lasting several months, should be a full-time clinical exposure. The students could be divided into small groups and rotated through the following areas: medical and surgical services; outpatient clinics and the emergency room; offices of private physicians; and neighborhood health facilities. Elective time could also be allotted to allow students to rotate through specialty departments of their own particular interest.

Setting for the training can also vary widely. Some high schools have already initiated programs to prepare students for health science careers. The college-level education might take place at a community college, a four-year college or university, or in the classrooms of a teaching hospital associated with an institution of higher education. The basic medical sciences would ideally be taught in a university or medical school, utilizing the basic

science faculty involved in other health sciences education. The clinical training must be carried out in a hospital or medical school.

A physician assistant training program should be flexible about each candidate's background; it should not take a "rule out, rule in" approach. Especially in the early stages of these programs, many people will be interested in becoming physician assistants who do not have the requisite science courses or who may have taken courses in related areas. College credits should be transferred and specialized credits should be given for other courses or clinical experience. Proficiency or placement examinations may aid in this process, but adequate counseling is essential. Another approach might be the development of parallel courses, with or without college credit but covering essentially the same basic material. The standards of quality for physician assistants may be established at the end of the training, either through graduation requirements or certification.

The mobility of physician assistants once they are trained should be similarly flexible. Individual physician assistants may become supervisors of other physician assistants on a service or in an institution; they may become instructors in training programs; or they may choose further training leading to a degree in medicine, dentistry, health care administration, and so on. Experience in other educational fields indicates that this kind of open-ended mobility is the best stimulus for achievement.

Unfortunately mobility into the professional schools may be the last to develop. Many of these schools have well-established criteria for admission and may be reluctant to accept students who do not possess the background afforded by a standard pre-medical program. There are some hopeful signs in those schools that are developing (or affiliating with schools for allied health professions) that strict adherence to such requirements is changing. As a final goal, we can envision a health sciences university with multiple entry points where prospective health workers at all levels would be trained in educational programs that allowed the maximum horizontal and vertical mobility for the graduates.

The physician assistant programs, then, are beginning to establish themselves as valuable sources of new health manpower which can provide more health care job opportunities for minority groups and low income communities. They may be able to provide primary care in a manner more consistent with the values of the indigenous population. Also, this new category of workers will begin to fill the gap in the health industry described by Fuchs;[8] they may begin to provide middle management and patient care skills between the doctor and the nurse that have heretofore been lacking.

Regulations must be developed to assure their proper responsibility and accountability to the physician. The setting of the training programs may vary from community college to university or university medical campuses. Above all, however, the training programs should be designed to allow multiple entry points and maximum retraining and mobility for the health workers.

With larger numbers of community residents involved in meaningful work, health institutions will become a more responsive and vital force for community improvement and good health.

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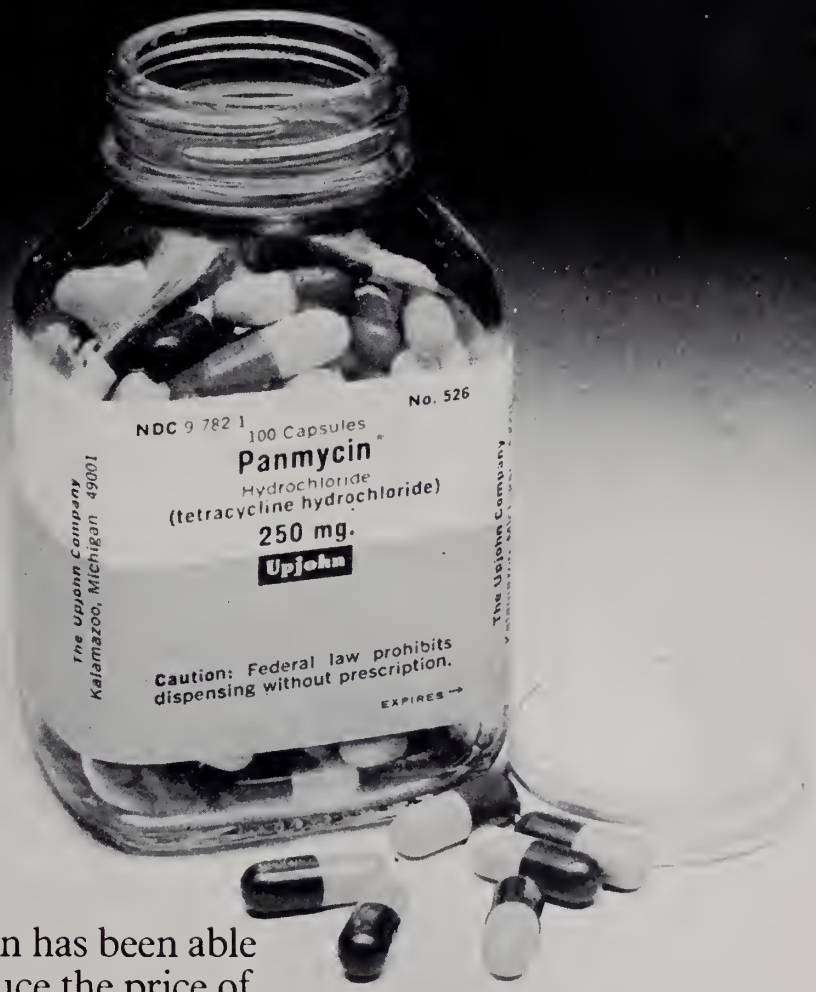
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Special Article

Here is something different from the traditional scientific paper—and perhaps more practical than some.

How to Get the Most Out of Medical Meetings

George L. Becker, Jr., M.D., Franklin Lakes

Medical meetings are not only a major source of graduate education, but also an industry of substantial proportions. During this past decade, I have viewed this phenomenon as an eager resident, chairman of a national meeting for over 1,000 surgeons, and now, as a somewhat more disillusioned critical attender of meetings. A critical view at the meeting phenomenon is intended.

Why go to meetings at all in this day of audio tapes, an enlightened press, and abundant journals? The three main reasons for physicians to attend medical meetings are: (1) knowledge (to know); (2) to wheel and deal—to be seen and heard by others; and (3) fellowship—to have fun.

The quest for knowledge predominates in evaluating a meeting's worthiness. A poor program will generally doom any meeting. Medical knowledge may be disseminated in many ways, but there is no substitute for the aggregation and the give-and-take of a medical meeting as an intellectual market place. Reputations are to be made, new positions and associates are to be secured, new medical products are to be evaluated and introduced, the heft of the latest from the instrument makers is to be tested, and medicine puts on its best face for the press.

Contemplate what a meeting will cost you, before you decide how attractive it is. If there are, say 21 papers in 3 days, and your total meeting expenses mount to over $300 you approach a cost to you of $15 per paper read. A hundred dollars a day is not unrealistic, when the cost of transportation to a distant site is taken into account. This does not reckon with the time out of the office, the patients turned away, and the like. Before you conclude that three days are too short, let me point out that a three-day meeting has been found to be most popular in the polls of a large specialty group. Are all those papers listed, worth the cost? The answer is probably not. Some are rehash, others are poorly presented, and others are peripheral to your interest. This shouldn't necessarily discourage you, but it is helpful in deciding what one can anticipate and what its monetary value is. Extending the cost accounting concept will help you determine whether there is advantage in consolidating a meeting and a family vacation.

Formal presentations are not the only scientific benefits of a meeting. Look for the others: Is there exposure to the great minds of medicine? Is there an opportunity to hear these giants debate the merits of varying treatments with others of differing opinions? Do you have a chance to ask your own questions of a panel group at the sessions or at the exhibits? Are there ample scientific exhibits to be pursued at your own pace? Are the commercial exhibits there of such quality that you can evaluate and purchase the latest in medicine, equipment, and books? Have the meeting planners excluded exhibitors whose sole purpose is high pressure salesmanship? Are there scientific and social functions, luncheons, luncheon discussion groups, breakfast sessions, and so on, including a banquet, where you can participate in an interchange of knowledge with your colleagues?

For an overlooked learning experience, look briefly in on the working medical press at a

big meeting. You will see true professionals with national reputations dissect away the superfluous as they dig for the real medical advances. What will surprise you is to see what they select for both lay and medical publications. You will learn what the pros say your patients and colleagues are interested in. It is not what the physician might expect would be important. A source of patient demand for our services comes from what patients read.

A reputable driver service relieves me of the difficult part of traveling: i.e., going to and returning from the home airport. Are you able to travel during a "thrift period?" If yes, there are considerable additional savings. A meal flight is a big time-saver—you don't have to eat when you arrive. Use the non-meal part of the flight time to study the meeting program and to apportion the time among the various meeting functions. The problem of room accommodation can be a thorny one, especially if room assignments are handled by a convention bureau. This has led some to obtain rooms, in the wife's name, by direct contact with a hotel, neglecting to mention the M.D. What is the weather like? A glance at the weather map in the hometown paper is especially helpful here. One of the joys of the three-day meeting is the opportunity to "travel light." Carry-on luggage means no waiting at the baggage counter, no lost luggage, and no waits for porters. A caution: pack it light; airports are getting bigger.

What to bring: Note pads and a supply of pens; a small flashlight for note-taking in totally darkened rooms; and, should you wish to photograph slides, a camera. In our own group, the doctor going to a meeting takes his cassette recorder to bring back the essentials of the meeting for those whose coverage allowed him to go in the first place. Key papers are taped entirely; lesser ones are summarized. If you plan to tape the meeting, check the meeting room for the best sound pick-up. If it isn't immediately obvious, the professional projectionist can point out the best spot for taping. Do you have some x-rays or data on a problem case that you would like to show the experts? If so, take this material along.

For many physicians, a meeting is a physical ordeal that far exceeds the stresses of their practices. First, he had to double his efforts to get away. Then, he goes at the last possible minute—this assures him of no chance to rest from the trip; no chance to adjust to time changes; no chance to compensate for travel delays.

If you have the chance to pre-register, do it. It helps your group plan the meeting and it saves you the deadly waiting in line, especially if you have just arrived, and are tired. The prudent physician arrives the night before, a little tired, but all signed in.

The knowledge explosion has forced modern meeting planners to plan simultaneous sessions. Often, there are at the same time papers, scientific movies, and scientific and commercial exhibits. You can't make them all. For this reason, use the plane trip to the meeting to find the time to plan the week's activities. Without advanced planning, it is easy to be caught up in the sensational and the close-at-hand, thus losing out on what would have been of practical value to you and your patients.

Many physicians come home from a meeting more tired than had they put in twice as many 18-hour days at home. I think that these physicians are acting more like their patients than as trained professionals. They work excessively hard to get away. They make no provision to get any rest; they eat and drink late and heavily and sleep poorly. They try to emulate scholastic learning as a medical student, decades before. Alas, middle life has deprived them of the "study all day and party all night habits" of their early 20's. It isn't easy to shave off all those extra calories accumulated at the "happy hour."

Two special types of meeting deserve some comment. At least once in your lifetime, treat

yourself to a meeting abroad. It is a delightful experience and tops for learning. One finds his foreign colleagues informed, polite, and especially hospitable. They often make available to you the opportunity to attend their clinics and hospitals, and to see firsthand, how well they handle problems. At the very least, you appreciate the one world of those who minister to the sick. The post convention tour is to be praised. Is it just a tax dodge? Not at all. Really, it is just an opportunity to attend scientific sessions in a more leisurely pace.

Jot down your expenses at day's end. In this way, justifiable deductions are not overlooked. On the plane home, read the literature acquired at the meeting. This is also the time to make notes from which you can later dictate letters and reports.

The best organizations have the prestige and reputation for attention to speakers' needs; thus, they attract the more desirable speakers. This type of group keeps in touch with members' educational needs, so that its programs are timely and more desirable. Since there is considerable competition for attractive meeting sites, a strong organization with good advanced planning most often has the best selection of good sites. One can infer from a poor choice of meeting site, that the group had begun planning late, or that planning was defective. Beware this meeting.

As an institution for graduate medical education, meetings should endure. There is no comparable way to disseminate the advances of medicine to practicing physicians as quickly. There is no other way that the peripheral functions, such as job hunting and organizational activities can be carried out. For such abuses as occur, particularly regarding the tax-deductible features, there can be expected more restrictions and limitations. For the individual physician, both the necessity of providing continuous service to patients, and the not inconsiderable expense involved limit attendance. Audio-taped highlights of a meeting are an already attractive alternative. The coming feasibility of video-taping should extend the value of the medical convention, and should do more to stimulate interest than to limit attendance. We all bemoan the more stringent regulations of medical practice, nonetheless, the requirement to attend at least some major medical meetings will strengthen our profession. We become better informed, yet, at the same time, gain some respite from the day's labors.

Clinical Center Study of Ovarian Carcinoma

The cooperation of physicians is requested in the referral of patients for a controlled clinical trial of the treatment of advance ovarian carcinoma being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Previously untreated patients with serous or undifferentiated ovarian carcinomas Stage III or IV (International Classification) are needed for this study. Of particular interest are patients with ascites, since pretreatment assessment of aspects of the cell cycle estimations of the effectiveness of each dose of administered drug and other studies are performed on available tumor tissue prior to therapy.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings. Physicians interested in having their patients considered for admission to these studies may write (including a brief clinical summary and representative slides) or telephone: Vincent T. DeVita, M.D., Clinical Center, Room 12-N-226, National Institutes of Health, Bethesda, Maryland 20014.

THE MEDICAL SOCIETY OF NEW JERSEY

Professional Liability Insurance Program

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

January 16, 1972

A regular meeting of the Board of Trustees was held on January 16, 1972, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Jesse McCall, M.D. . . . Observed a moment of silent prayer in tribute to the memory of Dr. Jesse McCall, 168th President of MSNJ, who died on January 14, 1972.

. . . Adopted the following memorial resolution and authorized a $50 contribution to the Medical Student Loan Fund in memory of Dr. McCall:

JESSE McCALL, M.D.
1906—1972

Whereas, Almighty God, in His inscrutable wisdom, has summoned our beloved and esteemed colleague, Jesse McCall, M.D.; and

Whereas, in his long years as a member, Doctor McCall consistently rendered splendid service to The Medical Society of New Jersey, as President, Treasurer, Trustee, Chairman of the Council on Legislation, and Speaker of the House of Delegates—to name but a few of the offices which he graced; and

Whereas, in his almost two-score years of practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, by his gentle graciousness and undeviating devotion to the highest ideals of mankind and the profession of medicine, he ever encouraged and inspired those with whom he came in contact; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to Doctor McCall's bereaved widow and family in token of heartfelt sympathy.

Symposium on Drug Abuse . . . Approved the action of the President in agreeing to have MSNJ listed as one of the cosponsors of a symposium on drug abuse being arranged by the New Jersey Public Health Association, to be held in New Brunswick on February 9, 1972. This action had the support of the Chairman of the Drug Abuse Committee, the President-Elect, and the Executive Officer. Other cosponsoring agencies are the Department of Health, the Department of Education, the Department of Law and Public Safety, the New Jersey State Bar Association, the New Jersey Association of Mental Health, the New Jersey Psychological Association, the Council of Churches, and the Congress of Parents and Teachers.

Chiropractors—Proposed Rule to Permit Use of Physical Therapy Modalities . . . Received the report from the Executive Director that the State Board of Medical Examiners had informed him that there was such a reaction of opposition to the proposed ruling to permit the use of physical therapy modalities by chiropractors that the proposed rule had no chance of adoption. In view of this, the Secretary of the Board of Medical Examiners regarded it as unnecessary to invite representatives of the Society to attend the Board's meeting on January 12th. MSNJ was assured that if further interest in the proposal developed the matter would be laid over and representatives of interested groups would be invited to present their arguments of opposition.

Transfusion-Association Hepatitis . . . Received a reply from the New Jersey Hospital Association that it had voted to endorse MSNJ's position on transfusion-associated hepatitis and to urge all member hospitals to call this matter to the attention of their staffs.

Note: Previous action of the Board of Trustees (September 19, 1971) had called for representatives of the New Jersey Blood Bank Association, the New Jersey Hospital Association, and the New Jersey Department of Health to discuss steps to encourage, through the hospitals, the use of greater numbers of voluntary blood donors from relatives and friends of patients,

especially in surgical situations, to help reduce the increasing number of transfusion-associated hepatitis cases.

Conference of Presidents . . . Authorized the scheduling of the Spring Conference of Presidents and Presidents-Elect of County Societies in conjunction with the March 19th meeting of the Board.

Woman's Auxiliary to the Student American Medical Association . . . Authorized MSNJ's sustaining membership in WA/SAMA at an annual membership fee of $15.

AMA Delegates . . . Received notice from the AMA Circulation and Records Department that as of December 31, 1971, MSNJ had 5,876 active members in the AMA which entitles MSNJ to six delegates. (Last year our quota was seven delegates.)

Policy Statement on Alcoholism . . . Approved the following policy statement on alcoholism (italics indicate amendment by the Board) prepared by the Committee on Alcoholism and approved by the Council on Mental Health:

Responsibility for Alcoholism

Alcoholism can be thought of from two *points of view*, (1) a medical syndrome; and (2) a sociological problem. As a medical syndrome in an individual patient, the care should ideally be directed by a physician. The use of paramedical personnel such as psychologists, social workers, A.A. members, rehabilitation workers, etc., is often essential. The treatment of alcoholism as a disease involves an attack on the total life situation of the patient, and ideally is approached *by the* team *method*. The director of such a team should be a physician familiar with the numerous medico-psychiatric problems of the alcoholic.

When alcoholism is approached as a sociological problem, medicine becomes only one of many components to be involved. The approach to the causes, prevention, control, and treatment of alcoholism should be *broadened. The responsibility for such an approach cannot be solely that of medicine. It should involve government, industry, private organizations, and education, as well as law and medicine.*

Policy Statement on Care of Mentally Retarded . . . Adopted the following policy statement on home care versus residential placement of the mentally retarded, which had been formulated by the Committee on Mental Retardation and approved by the Council on Mental Health:

Home Care of the Mentally Retarded Versus Residential

It is the judgment of the Committee on Mental Retardation that very often the primary physician recommends residential placement of a mentally retarded infant or young child. This early recommendation in many instances is detrimental to the infant or child and may also lead to a guilt complex on the part of the parents.

It is recognized that there are some circumstances under which early residential care is timely and essential.

There are valid reasons for home care of the young retarded person, regardless of whether one looks at the problem from the viewpoint of society, the parent, or the child. Society, the taxpayer, is saved enormous sums of money by home care rather than traditional residential care. Furthermore, indiscriminate residential placement places infants and children in beds who do not need extensive rehabilitation or 24-hour nursing care, thus depriving infants and children who do need this residential placement of access to beds in institutions.

From the parent's viewpoint, home care essentially is preferable because it permits sufficient time for the parents to make a rational plan for the care of the child. This permits parental decision based on facts and experience rather than on a professional opinion alone. The retarded child benefits from home care by receiving love, sibling contact, and a greater emotional development. It permits the mother-child relationship in stimulating emotional maturation as well as physical care. A second argument for home care is that often initially there is an inaccurate assessment of the degree of mental retardation, which could be catastrophic to the child if early residential placement has occurred.

The early residential placement of a victim of Down's Syndrome is usually not indicated. This deprives the child of emotional maturation, adjustment to society, and the realization of his or her full potential. Most of these children can attend kindergarten and special classes in the regular school systems, thus permitting additional emotional maturation and development, which are lost in a residential setting.

It is thus recommended that residential placement for the mentally retarded infant or child be held off as long as possible, with the final decision being made by the parent, with professional guidance.

With the approval of this statement, the Committee will meet with Dr. Samuel J. Lloyd, Chief Medical Consultant for the Department of Institutions and Agencies, Dr. Maurice Kott, Director, and Mr. Bernard White, Deputy Director of the Division of Mental Retardation, to prepare procedures for Institutions and Agencies to be used in the determination of admission of a child to an institution.

Continuing Education for Physicians . . . Directed that the following recommendation from the Committee on Medical Education be tabled without prejudice:

That in order to continue active membership in MSNJ, members must participate in approved programs of continuing education for a total of 150 hours in a given three-year period. (A program accredited by either the AMA Council on Medical Education or MSNJ's Committee on Medical Education is acceptable.)

Note: Legislation has been enacted in New Mexico which requires physicians licensed in New Mexico to participate in a continuing education program as a condition to continued licensure. Florida, Arizona, California, Kansas, Missouri, Oregon, and Pennsylvania have made participation in the AMA Recognition Award Program essential to continued Society membership. The MSNJ Committee on Medical Education feels that legislative mandating of continuing education is not necessarily an undesirable concept and believes that the Society should be aware that there is a real possibility of such action.

Medical Education and Community Orientation (MECO) . . . Approved the following recommendation from the Committee on Medical Education:

That the Board of Trustees approved the establishment of the MECO Program in New Jersey (a Student American Medical Association project), with the understanding that the necessary legal details will be clarified between the medical schools and the State Board of Medical Examiners.

Project Hope Fellowship for Dr. Flanagan . . . Approved a recommendation from the Committee on Project Hope and Vietnam for a $1,000 fellowship to John J. Flanagan, M.D. (Monmouth County) for a tour of duty to Kingston, Jamaica, January 15, to March 15, 1971.

. . . Referred to the Committee for clarification the question of whether a fellowship should be granted to a physician after his tour of duty has been completed.

New Jersey Regional Medical Program Liaison Representative . . . Designated Louis K. Collins, M.D. of Glassboro to succeed Joseph R. Jehl, M.D., who resigned, as the Society's official liaison representative to the New Jersey Regional Medical Program.

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Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during January 1972:

	1972 January	*1971 January*
Aseptic meningitis	12	20
Primary encephalitis	0	3
Hepatitis: Total	395	502
Infectious	317	409
Serum	78	93
Malaria: Total	4	14
Military	4	4
Civilian	0	10
Meningococcal meningitis	2	2
Mumps	195	314
German measles	48	22
Measles	190	14
Salmonella	74	73
Shigella	33	40

Influenza in New Jersey 1971-72

The State Health Department used the traditional tool of excess school absenteeism as the chief surveillance mechanism this year in mapping out influenza activity throughout our State. While other areas of the United States still seemed to be reporting significant amounts of influenza A_2 at the end of January, the disease seemed to be on the downswing in New Jersey.

The first reports of influenza A_2 activity came from Passaic County in mid-December. The first virologic as well as serologic confirmations were obtained from cases in Passaic County and then Sussex County, just prior to Christmas-time. The antigenic characteristics of the influenza A_2 virus recovered from all of the patients this year seem to be very similar, if not identical, to the Hong Kong strain. Subsequent to the laboratory confirmation in northern New Jersey, additional isolates as well as antibody rises were obtained from patients from throughout New Jersey.

The outbreak appeared to reach its peak during the first two weeks of January, at least as the extent of disease activity was reflected in school absenteeism. In the last two weeks of January, the number of schools with excessive absenteeism dropped precipitously and markedly. There were still pockets of influenza A_2

activity scattered throughout the State at the end of January, but no evidence of widespread disease. In general, the outbreak seemed to start in north Jersey and gradually moved southward.

The clinical manifestations of the influenza this year appeared to be milder than in 1968. The reasons for this are not clear at the present time, particularly in view of the fact that the virus strain causing the influenza appears to be the Hong Kong strain. There were at least six deaths virologically confirmed as having been caused by influenza. Because mortality data lag by a month to six weeks, the true extent of influenza-related mortality will not be known for another one to two months.

We wish to thank those of you who assisted us in obtaining either viral specimens or serologic confirmation of disease. As usual, we will be sending out recommendations for influenza vaccine next October or November.

Guidelines on Combination Products

The second FDA regulation, published in October 1971, tries to clarify the conditions under which combination drug products will be permitted to remain available, or be introduced anew for prescribing.

A controversy involving the medical profession, drug manufacturers, and various elements of pharmacy has been smoldering since February of 1971, when the FDA issued its proposed policy on fixed combinations. Those guidelines had a strong "anti-combination" flavor, representing an attitude prevalent in some areas of academic medicine.

The final guidelines, which are under continuous review, represent a more moderate viewpoint on the part of the FDA, while at the same time retaining the basic authority to move against combination products it considers to be in non-compliance with effectiveness criteria. The FDA guidelines state:

"A. Two or more drugs may be combined in a single dosage form when each component makes a contribution to the claimed effects and the dosage of each component (amount, frequency, duration) is such that the combination is safe and effective for a significant patient population requiring such concurrent therapy as defined in the labeling for the drug. Special cases of this general rule are where a component is added: (1) to enhance the safety or effectiveness of the principal active component and (2) to minimize the potential for abuse of the principal active component.

"B. If a combination drug presently the subject of an approved new-drug application or antibiotic monograph has not been recognized as effective by the Commissioner of Food and Drugs based on his evaluation of the appropriate NAS-NRC panel report, or if substantial evidence of effectiveness has not otherwise been presented for it, then formulation, labeling, or dosage changes may be proposed and any resulting formulation may meet the appropriate criteria listed in paragraph (A) of this section."

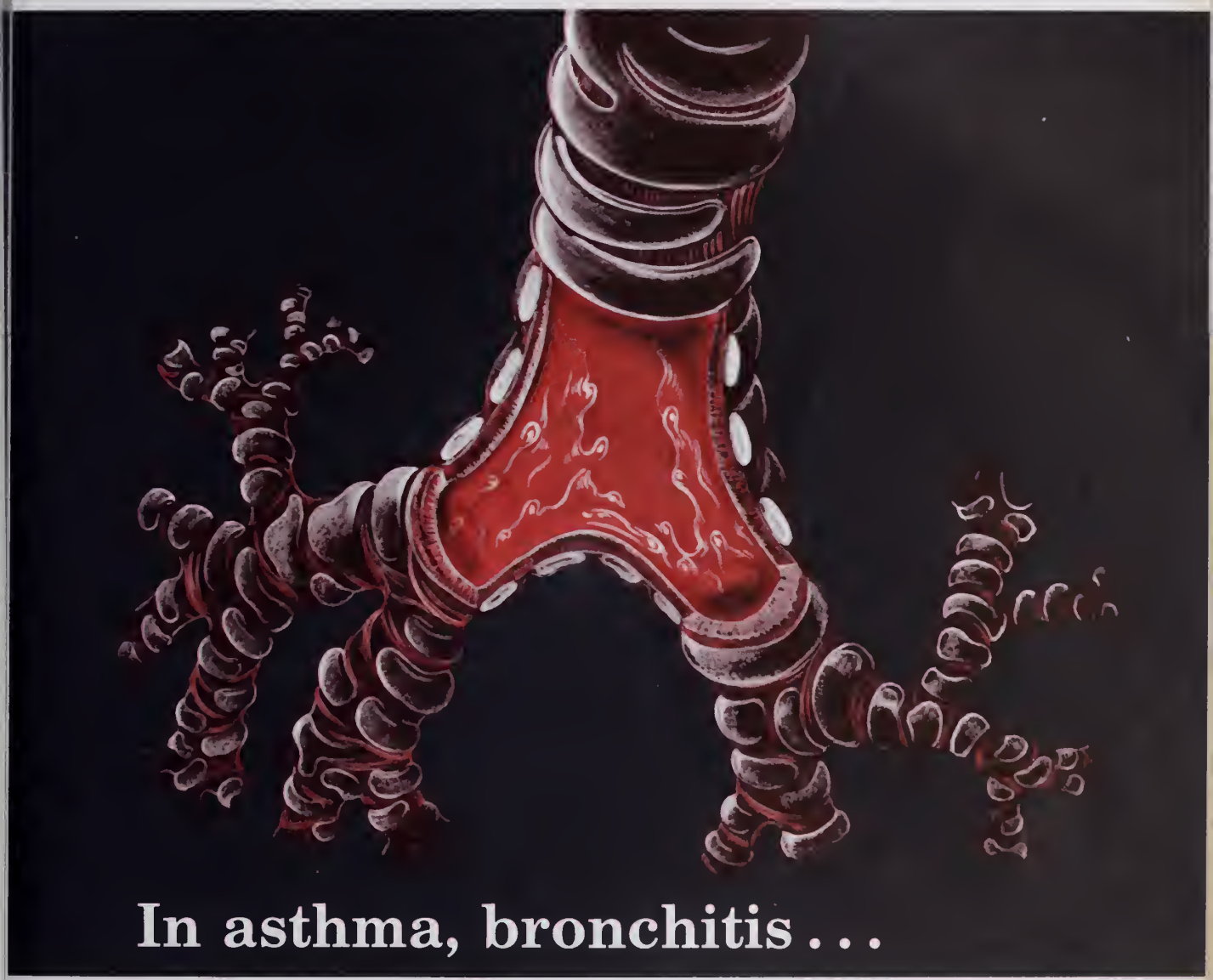
The essence of the new guidelines is that the FDA will continue to evaluate individual products that combine active ingredients in fixed ratios, probably moving cautiously against those with strong clinical support but seeking to remove from the marketplace those that have, in its opinion, more tenuous reasons for existence.

ATTENTION COMPONENT SOCIETIES

Please Note!

The 206th Annual Meeting of MSNJ will be held **May 6 to 9, 1972.** Please schedule your county meeting for election of delegates and alternate delegates so that the names can be forwarded to the Executive Offices no later than **April 1, 1972.**

MOVE-OUT STICKY MUCUS...



In asthma, bronchitis...

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

"For the viscid sputum, potassium iodide (...preferable as enteric coated tablets) may be best."[2]

Provide tastefree, well-tolerated KI in convenient SLOSOL coated tablets–

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Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

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Promote Productive Cough-



"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

". . . there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *ij* tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.



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Proposed Amendment to MSNJ Constitution

The following proposed amendment to Article 5, Section 2, of the Constitution of The Medical Society of New Jersey, which was approved by the 1971 House of Delegates and published in the July 1971 issue of *The Journal,* page Tr 52, (in compliance with Section B of Article 12—Procedure for Second Year) is here reprinted for the information of the membership. A copy of the proposed amendment, with a covering memorandum, was mailed to each component society under date of February 2, 1972:

Constitution
Article V—House of Delegates
Section 2—Speaker

Current	*Proposed*
Speaker	Speaker *and Vice-Speaker*
The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.	Same
	The President shall also have the power to appoint a Vice-Speaker of the House of Delegates at each annual meeting. The Vice-Speaker shall be a member of this Society, and his duty shall be to assist the Speaker in presiding at the sessions of the House of Delegates. He shall not have the power to appoint committees.

Your Fees and the Freeze

Regulations now require that a physician maintain a schedule of fees and increases with a sign in his office that such a schedule is available for inspection. But he does not have to post the fees in his office.

After issuance of the regulations, AMA officials continued meetings with Federal officials in efforts to effect modifications of provisions considered unfair to physicians. At one meeting Dr. Max H. Parrott, chairman of the AMA Board of Trustees, voiced strong opposition to some of the price control provisions which would deny treatment equal to that given other providers of professional services.

The AMA has pointed out that the Price Commission's 2.5 per cent limitation on the increase of physicians' fees was discriminatory inasmuch as other providers of services could reflect actual increases in cost by a "pass through" of such costs, a procedure denied physicians under the proposed regulations. The AMA also pointed out that while the Price Commission urged increased physician productivity, the proposed regulations might well decrease productivity.

The physician cannot generally work longer hours than he is presently working, the AMA position paper said. He can expand his office space, purchase new testing and diagnostic aids, and employ more staff. But, held to a 2.5 per cent fee increase—in the face of higher costs—he is apt to do none of these things. The AMA paper also took exception to the proposed requirement for the posting . . . or having available . . . a fee schedule. It is simply not practical for a physician to arrive at a schedule of prices for each and every one of the numerous services he renders, the AMA said, pointing out that it was its understanding that the Committee on Health Services Industry . . . an advisory body to the Price Commission . . . recognized this and had recommended that posting be limited to institutional providers.

The proposed guidelines do not provide for a procedure under which physicians whose fees are below the norms in their communities may adjust their fees. Physicians usually maintain their fees for several years and then increase them by ten or twenty per cent to counter inflation, rather than impose annual increments of 25 or 50 cents.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhaeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonarrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

High cure rate:* 96% of 571 males, 95% of 294 females
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by culturol identitication of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis ond patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 groms (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramusculorly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with o concentration of spectinomycin dihydrochloride pentohydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing in vitro susceptibility of *N. gonorrhoeae.*

Human pharmacology: Rapidly absorbed ofter intromuscular injection. A two-gram injection produces peok serum concentrotions averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averoging 160 mcg/ml ot two hours with 31 mcg/ml ot 8 hours.
For additional product information, see your Upjohn representative or consult the packoge insert. MED-B-1-S (LWB)

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For further information please contact Sister Marie Cecilia, O.S.F.
Administrator 609-896-9500

ANNOUNCEMENTS

Geriatric Meeting in New York

The American Geriatric Society will hold its Annual Meeting at the Americana in New York City, April 5 and 6. The program includes lectures on geriatric topics, reports on new research in the field, and panel discussions. For more information, write to Edward Henderson, M.D., American Geriatrics Society, 10 Columbus Circle, New York 10019.

Clinical Application of Basic Sciences

In the "Clinical Application of Basic Sciences" series offered by the Burlington County Memorial Hospital (supported by an educational grant from Merck, Sharp, and Dohme) the following programs have been announced for April:

April 6 Interservice Seminar
April 13 Thermography
April 20 Radiographic Technics in Gastrointestinal Disease
April 27 Diseases of the Esophagus

Meetings are held at 3:30 p.m. in the T. J. Summey Building of the Hospital. The Academy of Family Practice gives one and a half credits per session. For additional information, please contact the Department of Medical Education, Burlington County Memorial Hospital, Mount Holly 08060.

College of Physicians to Meet in Atlantic City

Immunology has been chosen as the theme for the April 17 to 21 meeting of the American College of Physicians to be held in Atlantic City. Other phases of internal medicine will be reviewed among the 120 papers to be presented. All scientific sessions will be held at the Convention Hall. For more information write to Dr. Edward C. Rosenow, Jr., American College of Physicians, 4200 Pine Street, Philadelphia 19104.

Parkinson Lecture

At 5 p.m., May 4, 1972, the third annual James Parkinson Lecture will be held in the Alumni Auditorium of the Columbia University College of Physicians and Surgeons on West 168th Street, New York City. The subject is cerebro-cerebellar interaction in the control of movement. The essayist is Sir John Eccles, a Nobel laureate in medicine and physiology.

Cytology Meeting

New Orleans is the place and November 1 to 4 are the dates for the next scientific program of the American Society of Cytology. For details, write to Warren R. Lange, M.D., at 7112 Lincoln Drive, Philadelphia 19119.

Patients with Reticulum Cell Sarcoma

Studies of reticulum cell sarcoma are now under way at the National Institutes of Health just outside of Washington, D.C. After the study and the therapeutic trial have been concluded, the patient will be returned to the referring physician, with full report and recommendations. For more details about this program, write to Vincent DeVita, M.D., Clinical Center, Room 12-N-226, National Institutes of Health, Bethesda, Maryland 20014.

Patients with Precocious Puberty

The National Institutes of Health are now accepting for study patients with precocious puberty. When studies and treatment are completed, the patient will be returned to the referring physician with a detailed report. For information about how to enroll your patient in this program, write to Howard Kulin, M.D., Clinical Center, Room 10-B-09, National Institutes of Health, Bethesda, Maryland 20014.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1972

March

9 **Burlington County Memorial Hospital**
Mount Holly
Family Life Problems in Medicine

14 **Academy of Medicine of New Jersey**
South Amboy Memorial Hospital
South Amboy
Renal Failure

15 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Pediatric Cardiology

15 **Bergen Pines County Hospital**
Paramus
Assisted Circulation in Myocardial Infarction

16 **Burlington County Memorial Hospital**
Mount Holly
Geriatric Psychiatry

16 **Fair Oaks Hospital**
Summit
Legal Provisions for Mental Health

22 **St. Clare's and Dover General Hospitals**
Secondary Nephropathies

22 **Academy of Medicine of New Jersey**
University of Pennsylvania Hospital
Philadelphia
Clinical Gastroenterology

22 **Academy of Medicine of New Jersey**
St. Michael's Medical Center
Newark
Arteriosclerosis

22 **Bergen Pines County Hospital**
Paramus
Arthritis: Diagnosis Criteria

23 **Burlington County Memorial Hospital**
Mount Holly
Alcohol: The Unglamorous Addiction

25 **Academy of Medicine of New Jersey Section on Plastic Surgery**
Kessler Institute
West Orange
Nerve Injuries of the Hand

29 **Bergen Pines County Hospital**
Paramus
Medical Aspects of Narcotic Addiction

29 **Academy of Medicine of New Jersey and American College of Chest Physicians**
Pulmonary Physiology

30 **Burlington County Memorial Hospital**
Mount Holly
Descent into Hell

30 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

30 **Fair Oaks Hospital**
Summit
The Expert Witness

April

5 **Bergen Pines County Hospital**
Paramus
CPC Meeting

6 **Burlington County Memorial Hospital**
Mount Holly
Interservice Seminar

10 **Academy of Medicine of New Jersey**
Saint Francis Health Center
Jersey City
Proper Use of Antibiotics

12 **Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: Implantology

12 **Bergen Pines County Hospital**
Paramus
Control Mechanisms in Intestinal Motility

13 **Burlington County Memorial Hospital**
Mount Holly
Thermography

13 **Fair Oaks Hospital**
Summit
Behavior Therapy

19 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Leukemia and Lymphoma

19 **Bergen Pines County Hospital**
Atlantic City
ACP Meeting

20 **Burlington County Memorial Hospital**
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases

22 **American Cancer Society**
Rutgers Medical School, Piscataway
Role of Primary Physician in Cancer Patient

25 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Current Burn Treatment

26 **Bergen Pines County Hospital**
Paramus
Ulcer Disease

27 **Burlington County Memorial Hospital**
Mount Holly
Diseases of the Esophagus

27 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

27 **Fair Oaks Hospital**
Summit
Behavior Therapy

May

3 **Bergen Pines County Hospital**
Paramus
Intravenous Hyperalimentation

4 **Burlington County Memorial Hospital**
Mount Holly
Syndrome of Stress Ulcer

6-9 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

10 **Bergen Pines County Hospital**
Paramus
Use and Abuse of Digitalis

11 **Burlington County Memorial Hospital**
Mount Holly
Zollinger-Ellison Syndrome

11 **Fair Oaks Hospital**
Summit
Brain Tumors

17 **Bergen Pines County Hospital**
Paramus
Malabsorption Syndrome

18 **Burlington County Memorial Hospital**
Mount Holly
Drug Interactions

18 **Academy of Medicine of New Jersey**
Mayfair Farms, West Orange
Annual Awards Dinner

24 **Bergen Pines County Hospital**
Paramus
Immunoglobulin Disorders

25 **Burlington County Memorial Hospital**
Mount Holly
Anticoagulants and Fibrinolytic Agents

25 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

25 **Fair Oaks Hospital**
Summit
Medical Aspects of Drug Abuse

31 **Bergen Pines County Hospital**
Paramus
Emphysema

June

7 **Bergen Pines County Hospital**
Paramus
Surgery in Coronary Artery Disease

8 **Fair Oaks Hospital**
Summit
Psychiatric Sociology

People like you helping people like you



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advertising contributed for the public good

ADVERTISING COUNCIL

Pre-Sate®
(chlorphentermine HCl)

CAUTION: Federal law prohibits dispensing without prescription.

Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request.

WC
WARNER-CHILCOTT
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Pre-Sate® (chlorphentermine HCl)...the increasingly practical appetite suppressant



What makes 'Deprol' useful for depressed geriatric patients... makes it useful for younger patients as well

- helps ease mild to moderate nonpsychotic depression *and* related anxiety
- helps assure a good night's rest



The middle-aged housewife who can't stop feeling "blue," who worries about losing her attractiveness yet neglects her appearance; reports vague aches and pains, difficulty sleeping, loss of appetite.

INDICATIONS: Useful in the management of depression, both acute (reactive) and chronic; particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination; also useful for management of depression and associated anxiety accompanying or related to organic illnesses.
CONTRAINDICATIONS: Benactyzine hydrochloride: Glaucoma and previous allergic or idiosyncratic reactions to benactyzine hydrochloride or related compounds. **Meprobamate:** Acute intermittent porphyria and allergic or idiosyncratic reactions to meprobamate or related compounds such as carisoprodol, mebutamate, tybamate, carbromal.
WARNINGS: The following information on meprobamate pertains to 'Deprol' (meprobamate + benactyzine hydrochloride): **Meprobamate:** *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, then gradually withdraw. *Potentially Hazardous Tasks:* Drivi a motor vehicle or operating machinery. *Additive Effects:* Possible ac tive effects between meprobamate, alcohol, and other CNS depressar or psychotropic drugs. *Pregnancy and Lactation:* Safe use not establishe weigh potential benefits against potential hazards in pregnancy, nursi mothers, or women of childbearing potential. Animal data at five tim the maximum recommended human dose show reduction in litter s due to resorption. Meprobamate appears in umbilical cord blood at near maternal plasma levels, and in breast milk at levels 2-4 times th of maternal plasma. *Children Under Six:* Drug not recommended.
PRECAUTIONS: Meprobamate: To avoid oversedation, use lowest eff tive dose, particularly in elderly and/or debilitated patients. Consider p sibility of suicide attempts; dispense least amount of drug feasible at a one time. To avoid excess accumulation, use caution in patients with co promised liver or kidney function. Meprobamate may precipitate seizu in epileptics.
ADVERSE REACTIONS: Nausea, dry mouth, other g.i. symptoms; s cope; one case each of severe nervousness and loss of power of conc tration. The following side effects, which have occurred after administrati of its components alone, have either occurred or might occur when t combination is taken. **Benactyzine hydrochloride:** Benactyzine hyc chloride alone, particularly in high dosage, may produce dizziness, thou blocking, a sense of depersonalization, aggravation of anxiety, or dis

When mild depression and associated anxiety interfere with living

DEPROL®

(meprobamate 400 mg + benactyzine hydrochloride 1 mg)



The junior executive crushed by his repeated failure to be promoted and anxious about the future; complains to you of listlessness, early-morning awakening.

The young widow whose grief has persisted too long, is pessimistic and fearful about what lies ahead, has lost interest in everything; is preoccupied with vague physical ailments, has crying spells.

bance of sleep patterns, and a subjective feeling of muscle relaxation. There may also be anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria. **Meprobamate:** *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.

USUAL ADULT DOSAGE: One tablet three or four times daily, which may be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended.

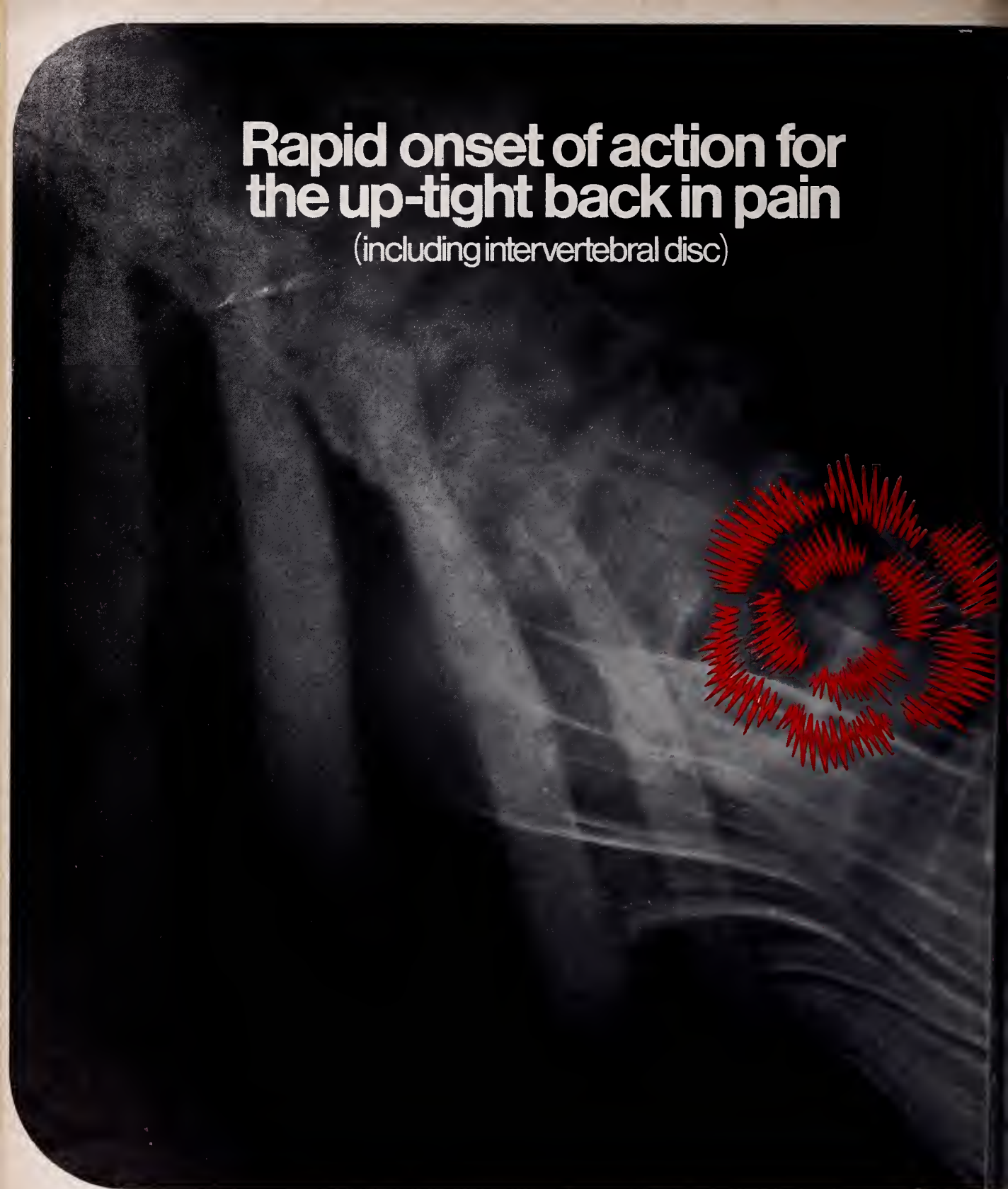
OVERDOSAGE: Overdosage of 'Deprol' (meprobamate + benactyzine hydrochloride) has not differed substantially from meprobamate overdosage. **Meprobamate:** Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV 10/71

Before prescribing, consult package circular or latest PDR information.

WALLACE PHARMACEUTICALS, Cranbury, N.J. 08512

Rapid onset of action for the up-tight back in pain

(including intervertebral disc)



Indications: For symptomatic relief in conditions characterized by skeletal muscle spasm and mild to moderate pain.
Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.
Warnings: *Idiosyncratic Reactions:* Rarely, first dose has been followed by extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion, disorientation. Symptoms usually subside during the next several hours. Supportive and symptomatic therapy, including hospitalization, may be necessary. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. *Children Under Five:* Drug not recommended. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between carisoprodol, alcohol, and other CNS depressants or psychotropic drugs. *Drug Dependence:* Use cautiously in addiction-prone patients.
Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.
Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia. *Allergic or Idiosyncratic:* Usually seen after 1-4 doses in patients not previously exposed e.g., rash, erythema multiforme, pruritus, eosinophilia, fixed drug

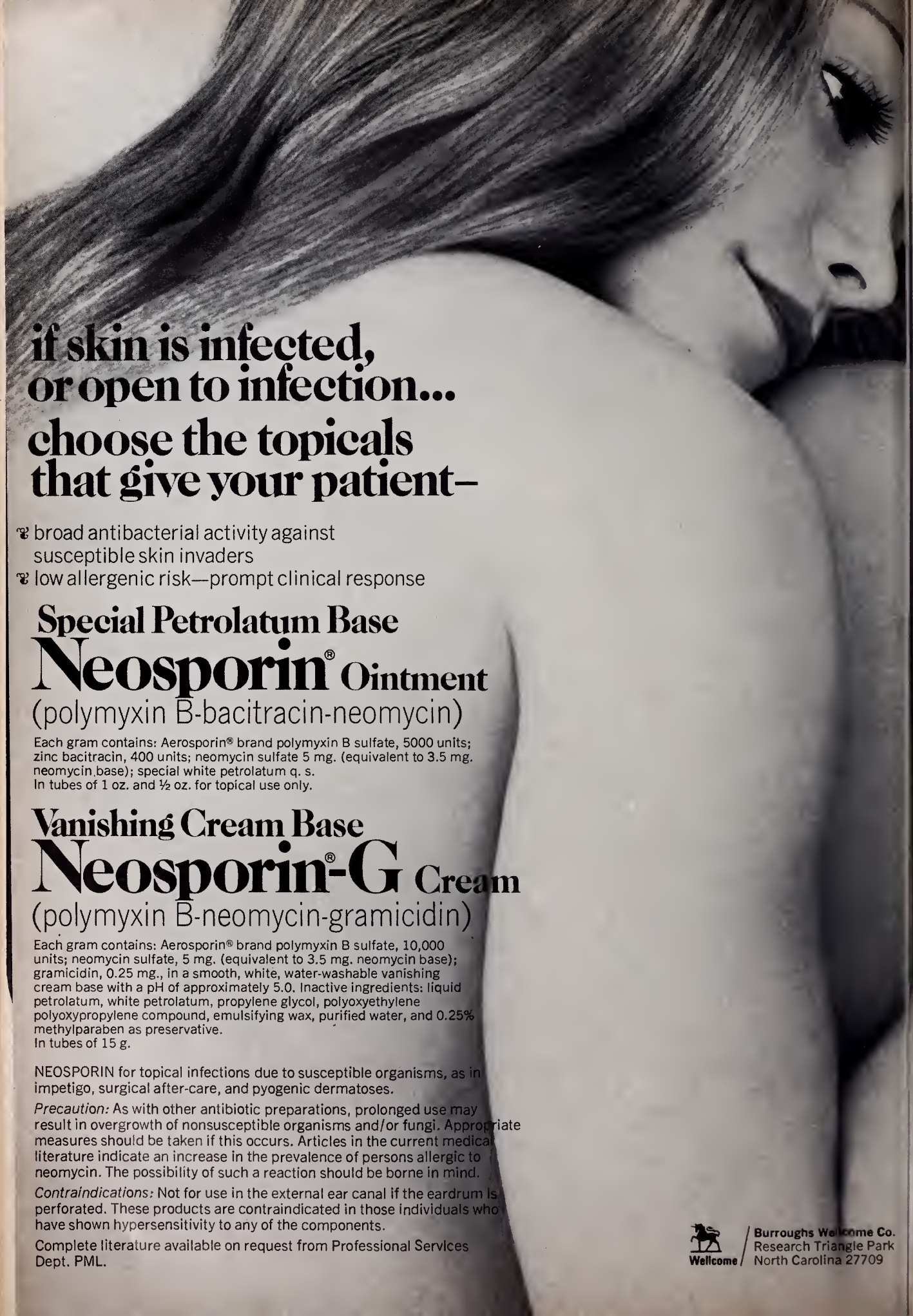


eruption with cross reaction to meprobamate. More severe manifestations: asthma, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension, anaphylactoid shock. Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Cardiovascular:* Tachycardia, postural hypotension, facial flushing. *Gastrointestinal:* Nausea, vomiting, hiccup, epigastric distress. *Hematologic:* Leukopenia and pancytopenia (on carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. Overdosage of carisoprodol plus alcohol or other CNS depressants or psychotropic drugs can be additive. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10/71

WALLACE PHARMACEUTICALS / Cranbury, N.J. 08512



if skin is infected, or open to infection...

choose the topicals that give your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

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LETTERS TO THE JOURNAL

How to Wipe Out All VD in One Day

January 3, 1972

Dear Sir:

Despite mass hand-wringing over the unchecked rise of venereal disease in this country to virtually epidemic proportions, no new bold initiatives have been forthcoming from venereologists or public health officials. VD control emphasis continues to be placed on finding infected cases, treating them, and tracking down their contacts. Public education programs continue to concentrate on prophylaxis, the recognition of symptoms to motivate individuals to seek treatment, and avoidance of questionable sexual partners.

Monumental problems often require unorthodox solutions. In my opinion, the most provocative suggestion to eliminate VD advanced to date is contained in an article written by psychiatrist, turned best-seller author, Dr. David Reuben in *McCall's,* June 1971. "If on the same day every person in the U. S. capable of having sexual intercourse were given a dose of antibiotic, gonorrhea and syphilis could probably be eliminated as serious public-health threats."

Reuben cited the eradication of gonorrhea from a group of Filipino prostitutes by the U. S. Navy by the administration of a single dose of oral penicillin along with a drug to prolong the antibiotic effect (undoubtedly probenecid). He concluded that this approach probably would never be adopted. "But the cost would be less than a week or so of the war in Indochina and the savings in money, time, and human suffering could be enormous."

The basis for Reuben's thesis, of course, lies in the fact that both syphilis and gonorrhea are unique in that they are contracted practically exclusively venereally and the majority of cases are curable by penicillin. It is true that for males with gonorrhea the Public Health Service recommends penicillin by a single delayed-action injection and when complicated by syphilis, an additional injection of long-acting penicillin. The same treatment schedule is recommended for infected females except that for gonorrhea the dose of penicillin is doubled. In penicillin allergy, alternative therapy consists of a four-day course of oral tetracycline.

Nevertheless, the literature already contains many reports of the successful treatment of gonorrhea in males with a single dose of penicillin derivative (e.g., ampicillin) and probenecid. The crucial question is: Can syphilis be cured by a single massive dose of penicillin (or other antibiotic) and probenecid? Obviously more research is needed, but such investigation would probably entail considerably less time and expense than the development of a vaccine against the venereal diseases.

Assume that a single dose of antibiotic and probenecid could cure both syphilis and gonorrhea in both sexes. Since the prophylactic and therapeutic regimens are identical such therapy would simultaneously (1) cure all infected persons, and (2) prevent the diseases in individuals incubating them. And if, on the same day, every person in the U.S. capabe of having sexual intercourse received such treatment, then the next day the country could wake up to a sexually unpolluted, VD-free America.

Many other questions immediately come to mind, notably: What age groups constitute "every person capable of having sexual intercourse?" Particular attention would have to be directed toward high-risk groups such as prostitutes, homosexuals, beatniks, hippies, and high school and college students.

As a refreshing approach to an old problem I believe the plan merits being dropped into Washington's "think-tank" for serious consideration. (signed) Sol Browdy, M.D.

Tribute to a True Physician

January 14, 1972

Dear Sir:

Dr. Jesse McCall was a man I wish I had known better and longer, because he had qualities that made others envious. His very manner labeled him a doctor. He seemed the kind of man who could make decisions rapidly and handle emergencies well. Even after his term as President of our Society, he served it well for many years as Speaker of the House of Delegates, often to a standing ovation from its members. He was fair but firm in his decisions. He could be humorous without being frivolous. As Chairman of the Council on Legislation he ran a well-organized meeting, and guided the discussion of each bill without favoritism.

I've never heard an unkind word about Dr. McCall, as a man, a physician, a legislator, or an officer of our Society. We are indeed richer for the years of dynamic service he has given to the medical profession of New Jersey. We will miss him, because there aren't many with the stature of Dr. McCall.

(Signed) John S. Madara, M.D.

TB Isolation Procedures

January 15, 1972

Dear Sir:

The Tuberculosis Respiratory Disease Association of New Jersey recently recommended[1] that community hospital patients with active pulmonary tuberculosis "be given full hospital privileges" soon after initiation of chemotherapy. This recommendation is based upon two studies[2] which are not convincing.

In one study from Madras, India,[3] patients in a control group were isolated from their families while receiving medication for active pulmonary tuberculosis while a group of comparable test patients took medications at home. Tuberculin tests and chest x-rays done over a two-year period uncovered the same incidence of new TB cases in the control group as in the test group. The report concluded that drug therapy must confer immediate non-infectiousness. As a corollary it suggested that isolation for active pulmonary tuberculosis is unnecessary all over the world.

If this study were valid, should not there have been a slight increase in new TB in the exposed families as a result of drug-resistant organisms? Should not the exposed families have had a higher disease rate because "some patients at home were irregular in taking their medication?"[3] It is puzzling how home TB therapy could be successful in a country where oral contraception was a total failure.

In the Madras study, the five unit OT skin test dose may not have been sensitive enough to pick up new cases of tuberculosis.[4] The two-year period of the study may have been shorter than the incubation period of primary tuberculosis, or the Madras population may have special characteristics which made the investigation invalid. The "malnourished, poverty-stricken, overcrowded sectors" of Madras are reminiscent of conditions in some Western cities before the advent of chemotherapy and in these Western cities almost the entire population harbored tubercle bacilli. If there were people in Madras with negative skin tests, it must be assumed that they are either anergic or immune. It is unwarranted to apply results from this group to the people in America.

Because of the deficiencies of this study, because the other study has its deficiencies, and because neither study has been confirmed, I respectfully urge that the policy of exposing patients with active pulmonary tuberculosis be re-evaluated with a view toward adopting the approach of more cautious experts.[5]

(signed) Jay A. Cohen, M.D.

References

1. Tuberculosis-Respiratory Diseases Association of New Jersey. Isolation procedures for tuberculosis patients in general hospitals. New Jersey, 1971.
2. Mitchell, R. S.: *New England Journal of Medicine*, 276:842 (1967)
3. Fox, W.: *Lancet*, 2:413 (1962)
4. Smith, D. T.: *Annals of Internal Medicine*, 67:919 (1967)
5. Tizes, R.: *New England Journal of Medicine*, 23: 1309 (1969)

OBITUARIES

Dr. William E. Boutelle

One of our state's leading psychiatrists, William E. Boutelle, M.D., died on January 9, 1972, at the age of 64. He was a 1936 graduate of the College of Physicians and Surgeons of Columbia University and had served at the State Diagnostic Center at Menlo Park. He was a pioneer in the child guidance field and for over a decade he directed the Somerset County Guidance Center. He was on active duty with the U.S. Navy during World War II. Dr. Boutelle was affiliated with the Somerset Hospital and with the Hunterdon County Medical Center.

Dr. Andrew E. Franzoni

Born in 1909, Andrew E. Franzoni, M.D., died in his 63rd year, on January 6, 1972. He was an obstetrician and gynecologist on the staff of St. Francis Hospital in Trenton. He was active in the affairs of the New Jersey Obstetrical and Gynecologic Society, and was a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Clarence O. Hilton

Essex County lost one of its senior physicians on December 10, 1971, with the passing on that day of Clarence O. Hilton, M.D. at the age of 78. Dr. Hilton was a 1927 alumnus of the medical school at Howard University. He was a family physician, serving for many decades as a Newark school doctor. He had worked with the staff of United Hospitals in Newark and was active in civic affairs in the Newark community.

Dr. Jesse N. Levitt

Jesse N. Levitt, M.D., an emeritus member of our Essex County Medical Society, died on January 8, 1972. Dr. Levitt was born in 1905 and earned his M.D. in 1930 at the Long Island College of Medicine. He was a surgeon on the staffs of the Martland Medical Center, the St. Barnabas Medical Center in Livingston, and the Newark Beth Israel Medical Center and United Hospitals. He was active in civic affairs in West Essex. Dr. Levitt was 67 years old at the time of his death.

Dr. Jesse McCall*

One of our State's best-known physicians, Jesse McCall, M.D., died of a heart attack on January 13, 1972, at the age of 66. In 1960 he was the President of The Medical Society of New Jersey, and from 1952 to 1957 he had been the Treasurer of our Society. He had been president of the Sussex County Medical Society, and was Speaker of the House of Delegates of The Medical Society of New Jersey.

Dr. McCall was a 1931 alumnus of the Medical College of the University of Virginia. A board-certified internist, he was active on the staff of the Memorial Hospital in Newton, New Jersey. During World War II he was a lieutenant colonel in the Medical Corps and served as chief of medicine at the large station hospital on Guadalcanal. For almost a decade he had served as a New Jersey delegate to the AMA.

Dr. Miriam Sachs

A widely-known expert in the public health field, Miriam Sachs, M.D., was only 60 years old at the time of her death on December 13, 1971. Her M.D. degree came from Columbia University in 1935. She was a diplomate of the American Board of Public Health and Preventive Medicine, and a consultant to our State's Commissioner of Health. She served for 16 years as chief of the Bureau of Adult and Occupational Health, and in 1958, she was appointed District State Health Officer in our State's Metropolitan State Health District. She also had had terms in the New York City and in the Maryland State Health Departments.

*Editorial comment on Dr. McCall's death appeared in the February issue of this *Journal*. Additional tribute in the form of a letter may be found on page 282 of this issue.

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BOOK REVIEWS

Preventive Medicine in World War II. Robert S. Anderson, E. D. Hoff, and P. M. Hoff, Editors. Washington, D. C., Office of Surgeon General, 1969. Pp. 603. Illustrated. ($8)

Twenty-six years have passed since World War II. The Historical Unit of the United States Army Medical Department continues to prepare and publish volumes describing the development, organization and performance of the medical personnel and installations all over the globe. In composing an all-inclusive official history it was found necessary to separate the volumes into two series, administrative and clinical. The clinical series covers five major subjects, one of which is *Preventive Medicine in World War II*. This most recent publication is Volume IX entitled *Special Fields*.

Volume IX consists of seven major chapters written by authorities in preventive medicine and public health. Nine of the contributors are affiliated with medical schools and government agencies who are experts in these fields. The tenth author, General Bayne-Jones, was the only member of the regular Medical Department of the United States Army. He wrote an absorbing chapter, "Enemy Prisoners of War." With no previous experience or historical background, most inadequate preparation, and with the Geneva rules for handling prisoners of war as a guide, the army suddenly was faced with the stupendous problem of controlling, feeding, housing, and caring for millions of prisoners of war from many different countries. How this was successfully accomplished with all the threatening hygienic and medical problems makes for fascinating reading.

The chapters on the training and education of enlisted and medical personnel in preventive medicine hygiene and tropical medicine describe not only the enormity of the task but also its effectiveness in the prevention and treatment of diseases existing in areas all over the globe. The chapter on "Disabilities Due to Environmental and Climatic Factors" is unusual because of the various operations in so many different areas, from the frozen north, the burning sands of the desert, to the steaming jungles. One will find the chapter on "Medical Intelligence" especially interesting. The chapter, "Medical Laboratories," is surprising. Medical laboratories of all types were developed, transported and displayed all over the globe. They provided adequate and efficient laboratory support to military organizations in the field as well as to civilians in many countries of the world. How this was accomplished is well described as are the other chapters with the help of 84 photographs, 23 tables, 14 charts and 11 maps.

Henry A. Brodkin, M.D.

Vitamin C and the Common Cold. Linus Pauling. New York, Bantam Books, 1971. Pp. 112 (Paperback, $1.25)

This compact book is written with vigor and directness by one of the keenest minds of our century. The use of Vitamin C in the common cold is his launch pad for an explosive attack on the "medical-scientific establishment." The facts, both pro and con, in this struggle about the efficacy of Vitamin C in preventing colds and improving health are meager, but the conclusions are far reaching. On one hand, Dr. Pauling infers that the pharmaceutical industry, professional journals, and even M.D.'s oppose his thesis on commercial, rather than on scientific grounds. He states that patients spend $500,000,000 per year on cold medicines which don't work very well and are fraught with toxic side reactions. Therefore, ascorbic acid, which is so cheap and essentially non-toxic, would be a better substitute for what we have except for the opposition of "the medical establishment." This reasoning repeats itself throughout the book. The text is written for the layman, but should be read by most M.D.'s since they are going to be asked questions by curious or worried patients. The whole book can be read in an hour. It is full of refreshing facts on a controversial subject by a partisan author who writes well and really means well. After all, how can you argue against an author with two Nobel prizes when you may not even have one?

Manuel J. Rowen, M.D.

Shands' Handbook of Orthopaedic Surgery. (Eighth Edition) R. Beverly Raney, Sr. and H. Robert Brashear, Jr. Saint Louis, Mosby, 1971. Pp. 543. Illustrated ($15.50)

As set forth in the preface, this book's primary goal is the "presentation of the fundamental facts and principles of orthopaedic surgery, concisely but in sufficient detail to convey a well-rounded knowledge of the subject." It succeeds in this objective and maintains its place as a favorite for medical students.

It has grown in size since the first edition of 1937 and even since I was a medical student some time later, but it must be said that this increase in size reflects our improved understanding of many orthopaedic conditions. Furthermore, it contains 419 photographs and drawings—almost all of excellent quality. Even more valuable is a bibliography which takes up 79 of the book's 543 pages and this refers the interested reader to more detailed reading on almost all the subjects covered in the book.

This book should be (and usually is) required reading for all medical students and provides the practicing physician with quick references to many of the problems he sees every day.

Peter N. Carbonara, M.D.

General Ophthalmology (Edition 6). Daniel Vaughan, M.D., Taylor Asbury, M.D., and Robert Cook, M.D. Los Altos, California, Lange Medical Publications, 1971. Pp. 316. Illustrated. ($8)

This ophthalmology text book is one of the best that I have seen for use by medical students and general physicians. It is quite complete, with large sections on some of the rarer ophthalmologic conditions such as the phankomatoses. The book is also up-to-date, containing interesting discussions on topics of recent interest, including genetics and retinal degenerations.

The format makes it easy to locate and absorb factual material as well as to understand the organization of ophthalmologic topics. Presentation is not dogmatic and the subject matter is not over-simplified. Although the authors state that this text was written with residents in ophthalmology in mind, I feel that the more important subjects such as glaucoma and strabismus are not treated in enough depth to satisfy these physicians.

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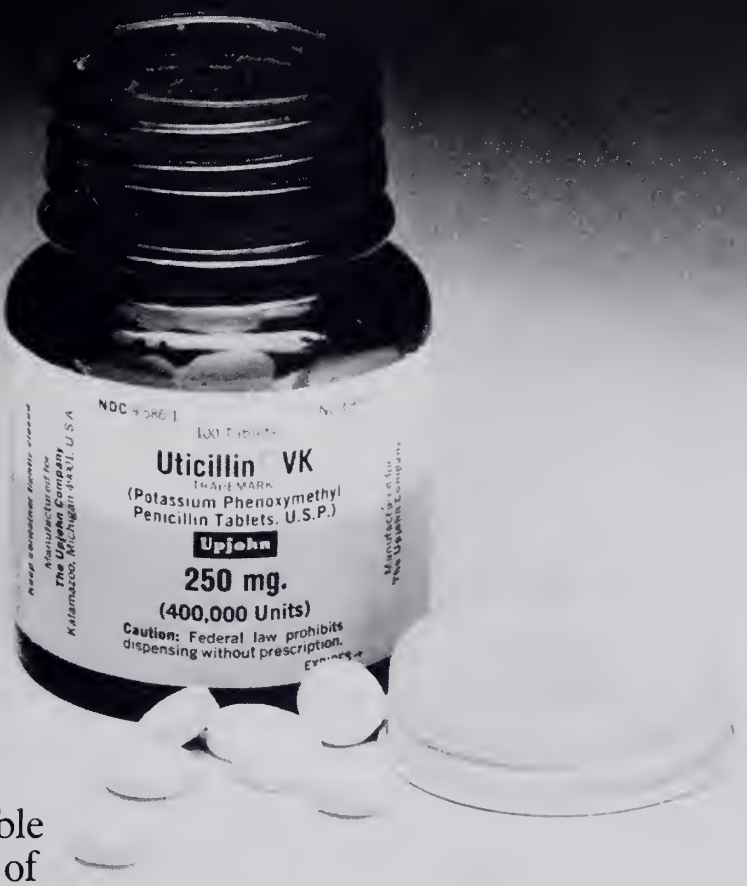
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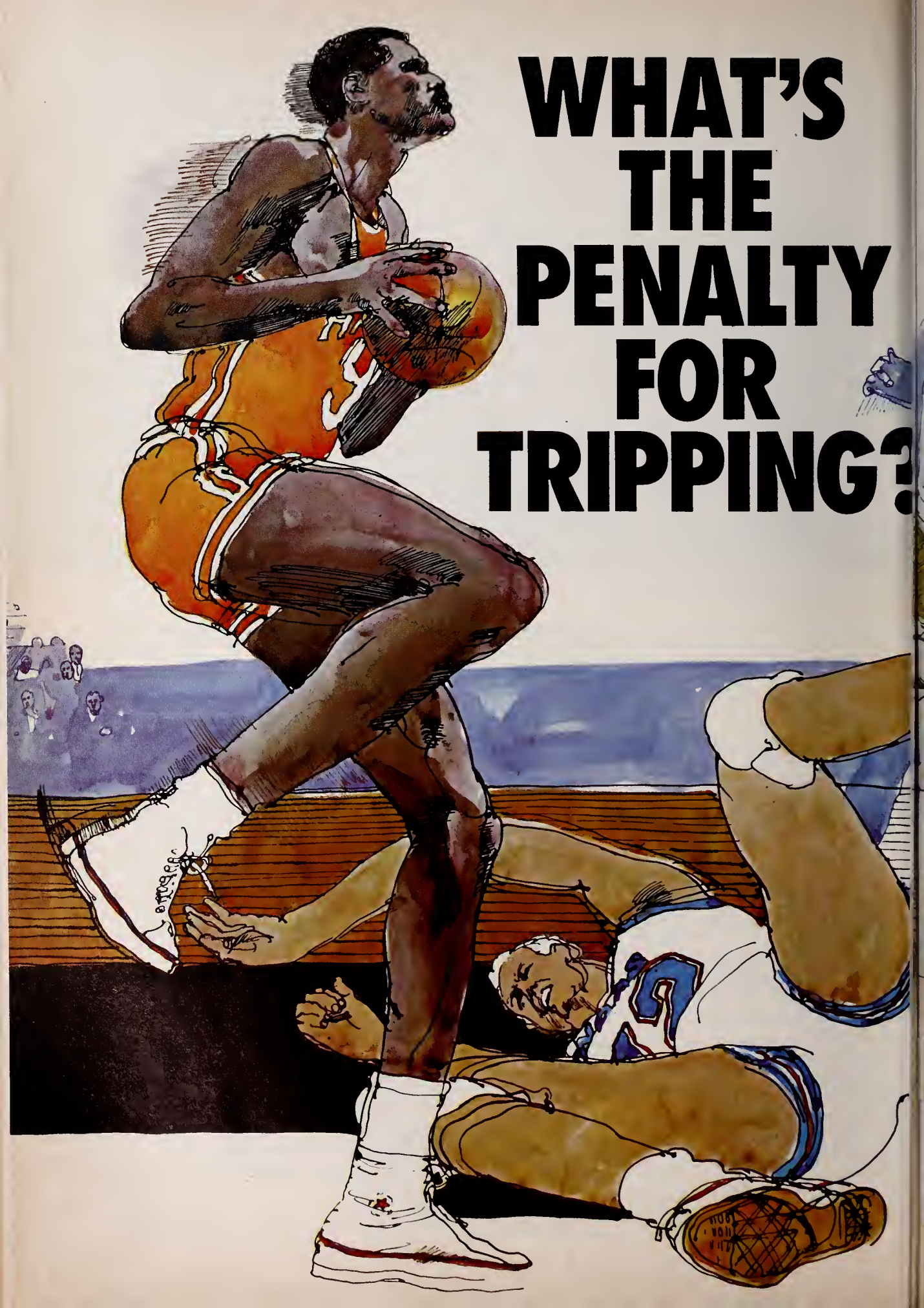
mportant Note: This drug is not a simple analgesic. Io not administer casually. Carefully evaluate patients efore starting treatment and keep them under close upervision. Obtain a detailed history, and complete hysical and laboratory examination (complete amogram, urinalysis, etc.) before prescribing and at requent intervals thereafter. Carefully select patients, voiding those responsive to routine measures, con-raindicated patients or those who cannot be observed requently. Warn patients not to exceed recommended losage. Short-term relief of severe symptoms with he smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of nilk. Patients should discontinue the drug and report mmediately any sign of: fever, sore throat, oral esions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discon-inue in the absence of a favorable response. Restrict reatment periods to one week in patients over sixty. *ndications:* Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis. *Contreindications:* Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy. *Warnings:* Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. 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Ulcerative esophagitis, acute end reactivated gastric and duodenal ulcer with perforation end hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with enemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilaterel renel cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravetion of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhege, toxic amblyopia, retinal detachment, hearing loss, hyporglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional stetes, lethargy; CNS reactions essociated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnie, ulcerative stomatitis, salivary gland enlargemont

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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– George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized, in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications line in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn, could notify the physicians in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: if drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

Maker of Medicine



Henry W. Gadsden, Chairman & Chief Executive Officer, Merck & Co., Inc.

In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

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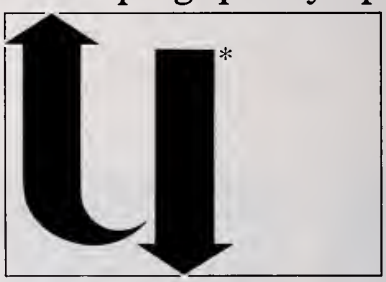
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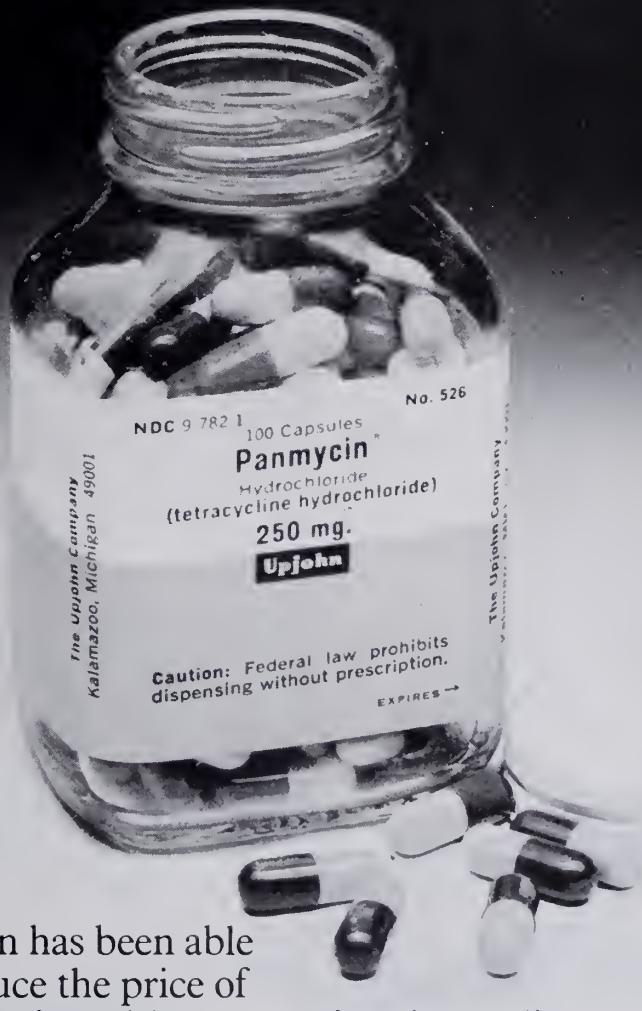
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EDITORIALS

Organized Medicine and the Democratic Method

It looks like a long and weary channel from you to your county medical society, to the state society, to the AMA. Obviously no organization of more than a thousand members can function like a small town meeting. Yet the individual doctor *can* make his voice heard. In February 1970, the Food and Drug Administration insisted on printed inserts in each package of anti-ovulatory pills. A Texas practitioner didn't like the wording, saw a threat to physician-patient rapport and an impediment to tailor-making the instructions to fit each patient's needs. Of course, thousands of physicians in the USA had the same reaction, but most of them said: "It's wrong, but I can't move either the AMA bureaucracy or the Federal bureaucracy." So, taking the "you can't fight city hall" attitude, most of us just shrugged our shoulders.

The Texas physician said what he thought at a meeting of his county medical society. They asked him to word a resolution. He did and it went to the Texas State Medical Association. Their House of Delegates sent it to one of their Reference Committees which held hearings, found general approval of the resolution, and so it was relayed to the AMA's House of Delegates. Again it went through the mill of reference committee debate and a vote in the AMA House. But the resolution was passed and FDA now heard official AMA policy. The agency changed the wording originally drafted for the package insert and eventually endorsed the AMA-worded pamphlet.

The whole process took ten months. But it worked. Organized Medicine still keeps open its communication channels in both directions. Your voice *can* be heard.

The Complete Physical

One of the by-products of advancing specialization is the decline of the complete physical examination. General practitioners seem to be the only ones left who can do this, and they often become discouraged by the frequency of "normal" findings. There isn't much glamor in doing a really meticulous physical examination, and the constant reiteration of "negative" becomes monotonous. Internists, who certainly *can* do complete examinations, often prefer to leave to the neurologist, the ophthalmologist, the orthopedist, the psychiatrist, and the otologist the responsibility for invading those areas of the psychobiologic unit. Thus, it may come to pass, that "complete physical examinations" will be relegated to exercises for junior medical students.

The general physical examination is actually the only instrument for handling the total human being. The examination also has certain emotional components. To the layman, the symbols of the physician are the stethoscope, the tongue depressor, and the blood-pressure cuff. The more thorough the examination, the more convinced that patient is that here is a friendly and scrupulous physician who knows what he is talking about. You and I know that many serious disorders do not, in early stages, manifest themselves in changes that can be picked up by physical examination. Nonetheless, the psychologic impact is there, and, in these days of self-criticism, is not to be neglected.

A careful examination is also a form of self-discipline. Cursoriness here becomes casualness in other facets of practice. It is also a technic of keeping up with medical progress. It is a way of re-establishing the thread of personal contact with patients that is threatened by the burgeoning of medical machinery. It is a recognition of the value of the laying on of hands. It is the badge of distinction of the physician. Many give health advice: nutritionists, psychologists, technicians, pharmacists, and others; but none does physical examinations, so this becomes idiomatic to the medical profession.

A Kind Word for the Drug Industry

A few years ago, Sir Derrick Dunlop said that "of the seventy most valuable drugs introduced to medicine in this century since the discovery of aspirin in 1899, sixty were discovered and developed by scientists in the laboratories of industry."

Let it be noted too that the research-based companies of the industry this year will be spending more than $600,000,000 on research and development—the highest ratio of research and development to sales of any U.S. industry. And this enormous effort comes from company earnings, not government dollars. Such an investment implies solid confidence in the capability of a uniquely diverse corps of chemists, clinicians, and other scientists to discover or develop products that can more effectively treat human ailments. The opportunities exist, so the financial risks will be taken. As we probe deeper into such promising areas as molecular biology, as we perfect newer technologies, this industry has the capacity to make the most significant kind of contributions. Hopefully, they can dwarf those of the past and present.

Because there are such opportunities, because they must be pursued unremittingly in the interests of sick people, the drug industry has an obligation to question the excessive cautions of bureaucracy, and to feel distressed at the rigidity of regulation. It is true that pharmaceutical companies make profits. Come to think of it, most of us expect to make money at *our* work. The scientists, physicians, and biochemists in this industry could do better—financially—in other fields. But, they have the satisfaction of knowing that, in a direct way, they are contributing to human health and life. And their dedication is evidenced by the "research and development" figures just cited as well as by the effectiveness of their product. Healing medications, products of industry-based research, are now available to the poorest American that no emperor could have obtained a century ago.

And Now Marantology?

Our esteemed contemporary, the *New England Journal of Medicine,* in an article in its January 1972 issue, reflects the view of William D. Poe, M.D., a Duke University internist. Dr. Poe suggests a new medical specialty devoted to providing peace, relief, and comfort to the dying and suggests that this new specialty be called "marantology" from the Greek *marantos* meaning withered, faded, or sere. Dr. Poe wants physicians to help people "die with dignity." He opposes last minute heroic measures, such as radical or mutilating operations, or sticking tubes and needles into dying patients. The way he puts it is this: "We should help people endure losing and not use euphemisms such as rehabilitation or convalescence for the losing patients. We should not send dear old people to intensive care units to be treated as winners." Marantologists, he reminds us, would not always look on death as an enemy, but often rather as a friend. He further wants the marantologist to "avoid becoming a do-gooder."

Specifically he asks: "What do you do with a 90-year old person whose functions are failing? Try to make him comfortable. You don't make him try to walk, talk, or eat, if he doesn't want to." He characterizes such efforts as pushing people around.

There is certainly cold logic in this thesis. But it represents an abandonment of hope, a shift from the traditional life-saving function of the physician. One trouble is that once the doctor assumes the right to decide who should be kept alive by heroic means and who should be allowed to die by medical inaction the door is open to opting in favor of abandoning heroic efforts, and with this the loss of a kind of spark that keeps us going when things look bad. Cold logic indeed may be with the marantological doctrine. But there are more important things in our work than either coldness or logic. Come to think of it, in making such decisions there is a kind of arrogance. The Greeks had a word for that too: *hubris.*

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The Medical Society of New Jersey

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Registration

Saturday, May 6, from 9:30 a.m. to 4:30 p.m.
Sunday, May 7, from 9:00 a.m. to 4:30 p.m.
Monday, May 8, from 8:30 a.m. to 4:30 p.m.
Tuesday, May 9, from 9:00 a.m. to 12 noon.

Golden Merit Award

Saturday, May 6, at 12 noon. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years. Reception following ceremony.

Motion Picture Theater

Saturday, May 6, at 2:00 p.m. Sunday and Monday, May 7 and 8, at 10:00 a.m. and 2:00 p.m. Program arranged and presented through the cooperation of Roche Laboratories, Division of Hoffmann-LaRoche, Inc., Nutley, New Jersey.

House of Delegates

First Session—Saturday, May 6, at 2:00 p.m.
Second Session—Sunday, May 7, at 3:30 p.m.
Third Session (Part I)—Mon., May 8, at 3:15 p.m.
Third Session (Part II)—Tues., May 9, at 9:00 a.m.

Reception-Buffet-Dancing

Saturday, May 6, 7:30 p.m. Special invitation is extended to members, official guests, their wives, and Auxiliary members. (Tickets are at Registration Desk—$10 per person)

Scientific Program: Scientific Sessions

Sunday, May 7 at 9:00 a.m.—
Allergy, Otolaryngology, Pediatrics
Ophthalmology
Sunday, May 7 at 9:30 a.m. (all day)—
Medicine, Cardiovascular Diseases, Radiology
Sunday, May 7 at 1:00 p.m.—
Anesthesiology
Psychiatry and Neurology
Urology
Monday, May 8 at 9:00 a.m. (all day)—
Obstetrics and Gynecology
Monday, May 8, at 9:30 a.m.—
Chest Diseases, Clinical Pathology
Dermatology, Plastic and Reconstructive Surgery
Orthopedic Surgery
Monday, May 8 at 1:00 p.m.—
Gastroenterology and Proctology,
General Practice
Rheumatism

Reference Committees

Saturday, May 6 at 3:00 p.m.—
Reference Committee on Const. and Bylaws
Reference Committees "A", "B", "D", "G"
Sunday, May 7 at 10:00 a.m.—
Reference Committees "C", "E", "F", "H"

General Session

Sunday, May 7, at 4:00 p.m.—President's Farewell Address; Inauguration of Incoming President; Address of Incoming President.

Reception for President-Elect D'Elia

Sunday, May 7 at 6:30 p.m. Invitation is extended to members, official guests, wives of members and guests, and Auxiliary members (Admission by badge)

Dinner-Dance

Monday, May 8 at 8:00 p.m. Invitation is extended to members, official guests, wives of members and guests, and Auxiliary members. (Tickets at Registration Desk—$12 per person)

Miscellaneous

Saturday, May 6 — New Jersey Committee on Trauma: 10:30 a.m. — Meeting; 12 noon — Luncheon; 1:00 p.m.—Annual Trauma Oration

Saturday, May 6 at 7:30 p.m.—Officers' Dinner (By invitation only)

Sunday, May 7 at 11:00 a.m.—Brunch: New Jersey Medical Woman's Association

Sunday, May 7 at 12 noon—Luncheon Meeting: New Jersey State Society of Anesthesiologists

Sunday, May 7 at 12 noon—Joint Luncheon:
New Jersey Chapter, Am. College of Cardiology
New Jersey Society of Internal Medicine
New Jersey Chapter, Am. College of Physicians

Sunday, May 7 at 12:30 p.m.—Luncheon Meetings:
New Jersey Academy of Ophthalmology and Otolaryngology
New Jersey Chapter, American Academy of Pediatrics

Sunday, May 7 at 8:00 p.m.—Inaugural Dinner (By invitation only)

Sunday, May 7 at 8:00 p.m.—25th Anniversary Banquet of the New Jersey Obstetrical and Gynecological Society

Monday, May 8 at 12 noon—Luncheon Meetings:
New Jersey Chapter, American College of Chest Physicians
New Jersey Obstetrical and Gynecological Society
New Jersey Orthopaedic Society

Monday, May 8 at 12:30 p.m.—Joint Luncheon:
New Jersey Chapter, Am. College of Surgeons
New Jersey Medical School, CMDNJ, Newark
Rutgers Medical School, CMDNJ, New Brunswick
Academy of Medicine of New Jersey

Monday, May 8 at 12:30 p.m.—Luncheon: New Jersey Society of Plastic and Reconstructive Surgeons

Monday, May 8 at 5:00 p.m.—Alumni Reception: College of Medicine and Dentistry of New Jersey

Monday, May 8 at 5:30 p.m.—Alumni Receptions:
Jefferson Medical College
Hahnemann Medical College

1972 Annual Meeting

DAILY SCHEDULE

Saturday through Tuesday
May 6 to 9, 1972

Chalfonte-Haddon Hall
Atlantic City

Friday, May 5, 1972

4:00 p.m.—Board of Trustees—Bakewell Room, 1st Floor, H H

Saturday, May 6, 1972

9:30 a.m.—Registration Opens — Exhibit Hall, Lobby Floor, H H

10:30 a.m.—Meeting: New Jersey Committee on Trauma, American College of Surgeons—Roberts Room, Lobby Floor, Chalfonte

12:00 noon—Golden Merit Award Ceremony
Reception for Award Recipients and Their Families
Rutland Room, 1st Floor, H H

12:00 noon—Luncheon: New Jersey Committee on Trauma, American College of Surgeons — Blue Room, Lobby Floor, Chalfonte

12:00 noon—Exhibits Open—Exhibit Hall, Lobby Floor, H H

1:00 p.m.—Annual Trauma Oration—New Jersey Committee on Trauma, American College of Surgeons — Roberts Room, Lobby Floor, Chalfonte

2:00 p.m.—Motion Picture Theatre — Library, Lobby Floor, H H

2:00 p.m.—House of Delegates—Windsor Room, Lobby Floor, H H

3:00 p.m.—Reference Committees:
Constitution and Bylaws — Mandarin Room, Tower Floor, H H
"A"—Rutland Room, 1st Floor, H H
"B"—Room 1344, Tower Floor, H H
"D"—Rowsley Room, 1st Floor, H H
"G"—Solarium, Lounge Floor, H H

5:00 p.m.—Nominating Committee — Bakewell Room, 1st Floor, H H

7:30 p.m.—Officers' Dinner—West Room, Tower Floor, H H
(By invitation only)

7:30 p.m.—Reception, Buffet-Dinner, Dancing—Vernon Room, Lounge Floor, H H
(Invitation is extended to members, official guests, their wives, and Auxiliary members—tickets at Registration Desk—$10.00 per person)

Sunday, May 7, 1972

9:00 a.m.—Registration and Exhibits Open — Exhibit Hall, Lobby Floor, H H

9:00 a.m.—Scientific Sessions:
Allergy, Otolaryngology, Pediatrics — Derbyshire Room, 1st Floor, H H
Ophthalmology — Solarium, Lounge Floor, H H

9:30 a.m.—Scientific Session:
Medicine, Cardiovascular Diseases, Radiology (all day)—Pennsylvania III, Lounge Floor, H H

10:00 a.m.—Motion Picture Theatre — Library, Lobby Floor, H H

10:00 a.m.—Reference Committees:
"C"—Mandarin Room, Tower Floor, H H
"E"—West Room, Tower Floor, H H
"F"—Rutland Room, 1st Floor, H H
"H"—Rowsley Room, 1st Floor, H H

11:00 a.m.—Brunch: New Jersey Medical Woman's Association — Tower Room, Tower Floor, H H

12:00 noon—Luncheon Meeting: New Jersey State Society of Anesthesiologists—Sylvan Room, Lobby Floor, Chalfonte

12:00 noon—Joint Luncheon: New Jersey Chapter, American College of Cardiology, New Jersey Society of Internal Medicine, and New Jersey Chapter, American College of Physicians—Pennsylvania III, Lounge Floor, H H

12:30 p.m.—Luncheon Meetings:
New Jersey Academy of Ophthalmology and Otolaryngology — Roberts Room, Lobby Floor, Chalfonte
New Jersey Chapter, American Academy of Pediatrics — Pavilion, 15th Floor, H H

1:00 p.m.—Scientific Sessions:
Anesthesiology — Solarium, Lounge Floor, H H
Medicine, Cardiovascular Diseases, Radiology (continued)—Pennsylvania III, Lounge Floor, H H
Psychiatry and Neurology — Derbyshire Room, 1st Floor, H H
Urology — Garden Room, Lounge Floor, H H

2:00 p.m.—Motion Picture Theatre — Library, Lobby Floor, H H

3:30 p.m.—House of Delegates (election)—Windsor Room, Lobby Floor, H H

4:00 p.m.—General Session—Addresses by President Davis and President-Elect D'Elia —Windsor Room, Lobby Floor, H H

6:30 p.m.—Reception Honoring President-Elect D'Elia — Pennsylvania Room, Lounge Floor, H H
(Invitation is extended to members, official guests, their wives, and Auxiliary members—admission by badge)

8:00 p.m.—Inaugural Dinner — Vernon Room, Lounge Floor, H H
(By invitation only)

8:00 p.m.—Twenty-Fifth Anniversary Banquet—New Jersey Obstetrical and Gynecological Society — West Room, Tower Floor, H H
(By invitation only)

Monday, May 8, 1972

8:30 a.m.—Registration Opens — Exhibit Hall, Lobby Floor, H H
8:30 a.m.—Scientific Session:
Surgery — Rutland Room, 1st Floor, H H
9:00 a.m.—Exhibits Open—Exhibit Hall, Lobby Floor, H H
9:00 a.m.—Scientific Session:
Obstetrics and Gynecology (all day) —Garden Room, Lounge Floor, H H
9:30 a.m.—Scientific Sessions:
Chest Diseases, Clinical Pathology—Solarium, Lounge Floor, H H
Dermatology, Plastic and Reconstructive Surgery — Rowsley Room, 1st Floor, H H
Orthopedic Surgery — Vernon Room, Lounge Floor, H H
10:00 a.m.—Motion Picture Theatre — Library, Lobby Floor, H H
12:00 noon—Luncheon-Meetings:
New Jersey Chapter, American College of Chest Physicians — Roberts Room, Lobby Floor, Chalfonte
New Jersey Obstetrical and Gynecological Society—Pavilion, 15th Floor, H H
New Jersey Orthopaedic Society — Mandarin Room, Tower Floor, H H
12:30 p.m.—Joint Luncheon: New Jersey Chapter, American College of Surgeons, New Jersey Medical School, CMDNJ, Newark, Rutgers Medical School, CMDNJ, New Brunswick, and Academy of Medicine of New Jersey—Rutland Room, 1st Floor, H H
12:30 p.m.—Luncheon: New Jersey Society of Plastic and Reconstructive Surgeons—Derbyshire Room, 1st Floor, H H
1:00 p.m.—Scientific Sessions:
Gastroenterology and Proctology, General Practice—Solarium, Lounge Floor, H H
Obstetrics and Gynecology (continued) —Garden Room, Lounge Floor, H H
Rheumatism — Rowsley Room, 1st Floor, H H
2:00 p.m.—Motion Picture Theatre — Library, Lobby Floor, H H
3:15 p.m.—House of Delegates—Windsor Room, Lobby Floor, H H
5:00 p.m.—Exhibits Close—Exhibit Hall, Lobby Floor, H H
5:00 p.m.—Alumni Reception:
College of Medicine and Dentistry of New Jersey — Rowsley Room, 1st Floor, H H
5:30 p.m.—Alumni Receptions:
Jefferson Medical College—Suite in Chalfonte
Hahnemann Medical College—Tower Room, Tower Floor, H H
8:00 p.m.—Annual Dinner-Dance Honoring President and Mrs. Davis—Pennsylvania Room, Lounge Floor, H H
(Invitation is extended to members, officials guests, their wives, and Auxiliary members — tickets at Registration Desk—$12.00 per person)

Tuesday, May 9, 1972

9:00 a.m.—Registration Opens — Exhibit Hall, Lobby Floor, H H
9:00 a.m.—House of Delegates—Windsor Room, Lobby Floor, H H
12:00 noon—Registration Closes — Exhibit Hall, Lobby Floor, H H
8:00 p.m.—Board of Trustees—Bakewell Room, 1st Floor, H H

VISIT THE EXHIBITS

A THREE-WAY TREAT

One of the colorful aspects of our convention is the interesting array of exhibits. This year, as usual, we have three classes—

Informational — Scientific — Technical

The exhibits help to defray the cost of your Annual Meeting. Take time to visit each booth. There is a wealth of new information available. Representatives will be present to answer your questions.

1972 Annual Meeting

GOLDEN MERIT AWARDS

Saturday, May 6 — 12 noon

Presiding

E. Vernon Davis, M.D., President

Master of Ceremonies

John J. Crosby, Jr., M.D., Chairman, Council on Public Relations

Marshals

Presidents of Component Societies whose members are receiving awards

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Recipients For 1972

County	Member
Bergen	Sadie Miller Blackman, M.D. Herman J. Horowitz, M.D. John Hawkins Irwin, M.D. Frederick Ludwig Marx, M.D.
Camden	Arthur Storey McCallum, M.D. Max Ruttenberg, M.D.
Cape May	Marcia Van Gilder Smith, M.D.
Essex	William Campbell, M.D. Ames Lawrence Filippone, M.D. Harold Herbert Goldberg, M.D. George Russell Henshaw, M.D. William James Marquis, M.D. Ellis Leon Smith, M.D. Samuel J. Soschin, M.D. Merton H. Stevens, M.D. Arthur Conrad Thornhill, M.D. Oscar Ulan, M.D.
Hudson	Sigmund Carl Braunstein, M.D. Samuel Ettinger, M.D. Edward Gilmay Waters, M.D.
Mercer	Hannah Elizabeth Seitzick-Robbins, M.D.
Middlesex	Francis Mann Clarke, Sr., M.D. Hyman Peter Fine, M.D. George Myron Walters, M.D.
Monmouth	Arthur Strauss, M.D.
Passaic	Herman Hale Hollingsworth, M.D. Gay Bong Kim, M.D. Donald Beardsley Low, M.D.
Union	Malcolm Shepherd Edgar, M.D. Frederick Theodore Hutton, M.D. James Julian Paul Linke, M.D.

Reception for Recipients and Families Following Ceremony

Annual Trauma Oration

Saturday, May 6, 1972 — 1:00 p.m.

Roberts Room, Chalfonte

Problems and Prospects in the Treatment of Traumatic and Hemorrhagic Shock

Benjamin F. Rush, Jr., M.D., Johnson and Johnson Professor of Surgery, and Chairman, Department of Surgery, College of Medicine and Dentistry of New Jersey.

The New Jersey Committee on Trauma of the American College of Surgeons will present its Annual Trauma Oration on Saturday, May 6, during the 206th Annual Meeting of The Medical Society of New Jersey. Preceding the lecture, there will be a meeting of the Committee at 10:30 a.m. in the Roberts Room and a luncheon at 12 noon in the Blue Room, Chalfonte.

(All members of The Medical Society of New Jersey and other physicians are invited to attend.)

Motion Picture Theater

Saturday, May 6 (afternoon)	Library
Sunday, May 7 (morning and afternoon)	Lobby Floor
Monday, May 8 (morning and afternoon)	Haddon Hall

Arranged and Presented Through

Roche Laboratories
Division of Hoffmann-LaRoche, Inc., Nutley

10:00 a.m. and 2:00 p.m.—Differential Diagnosis of Parkinsonism

10:15 a.m. and 2:15 p.m.—Psychiatric Technics for the Family Doctor

11:15 a.m. and 3:15 p.m.—Treatment of Parkinsonism with Levodopa

11:30 a.m. and 3:30 p.m.—Attorney/Physician Cooperation in the Defense of Medical Malpractice Cases

1972 Annual Meeting

RECEPTION

Saturday, May 6 — 7:30 p.m.

Cocktails

Buffet

Dancing

Martin King Associates Orchestra
(Tickets at Registration Desk)

1972 Annual Meeting

DINNER-DANCE

Monday, May 8 — 8:00 p.m.

Honoring

President E. Vernon Davis

Toastmaster

Richard I. Nevin

Welcome

Mrs. Donald A. McLean, President
Woman's Auxiliary

Introductions

Mrs. Charles Gandek, President-Elect
Woman's Auxiliary
William J. D'Elia, M.D., President-Elect
The Medical Society of New Jersey

Presentations

Fellow's Key
To: E. Vernon Davis, M.D., President
By: Emanuel M. Satulsky, M.D., Immediate Past-President

Fellowette's Pin
To: Mrs. Donald A. McLean
President, Woman Auxiliary
By: E. Vernon Davis, M.D., President
The Medical Society of New Jersey

Entertainment—Mel Ehrin
"From Concert to Comedy"

Music and Dancing

Martin King Orchestra Associates

1972 Annual Meeting

REFERENCE COMMITTEES

Saturday, 3:00 p.m. — May 6, 1972
Sunday, 10:00 a.m. — May 7, 1972

Reference Committee on Constitution and Bylaws
Mandarin Room, Tower Floor

Reports of the:
- Committee on Revision of Constitution and Bylaws
- Amendments to Constitution
- Amendments to Bylaws

Reference Committee "A"
Rutland Room, First Floor

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials

Reference Committee "B"
Room 1344, Tower Floor

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund
- Committee on Project Hope/Vietnam

Reference Committee "C"
Mandarin Room, Tower Floor

Reports of the:
- Medical-Surgical Plan of New Jersey
- Committee on Medical Defense and Insurance
- Committee on Retirement Plan for Physicians

Reference Committee "D"
Rowsley Room, First Floor

Reports of the:
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Emergency Medical Care

Reference Committee "E"
West Room, Tower Floor

Reports of the:
- Council on Legislation
- Council on Public Relations

Reference Committee "F"
Rutland Room, First Floor

Reports of the:
- Council on Medical Services, and its Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation
- Council on Mental Health, and its Special Committees on:
  - Alcoholism
  - Drug Abuse
  - Emotional Disorders of Childhood and Adolescence
  - Mental Retardation
  - Neurological and Related Disorders

Reference Committee "G"
Solarium, Lounge Floor

Reports of the:
- Council on Public Health, and its Special Committees on:
  - Cancer Control
  - Child Health
  - Conservation of Vision, Hearing, and Speech
  - Environmental Health
  - Maternal and Infant Welfare

Reference Committee "H"
Rowsley Room, First Floor

Reports of the:
- Committee on Annual Meeting, and its Special Committees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Advisory Committee to the Woman's Auxiliary
- Nominations for Emeritus Membership

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

1972 Annual Meeting

HOUSE OF DELEGATES

Saturday, 2:00 p.m.	May 6, 1972
Sunday, 3:30 p.m.	May 7, 1972
Monday, 3:15 p.m.	May 8, 1972
Tuesday, 9:00 a.m.	May 9, 1972

President—E. Vernon Davis, M.D., Mount Holly Secretary—Louis F. Albright, M.D., Spring Lake
Speaker—Henry J. Mineur, M.D., Cranford
Vice Speaker—Edward Foord, M.D., Burlington

Sessions

Saturday, May 6—2:00 p.m.

First Session

Invocation
The Reverend Watson E. Neiman, M.D.
Trinity Episcopal Church, Moorestown

Call to Order by the Speaker
Henry J. Mineur, M.D.

Organization of the House

Transactions of the 1971 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

Sunday, May 7—3:30 p.m.

Second Session

Report of Nominating Committee

Election

Inauguration of Incoming President

(At the conclusion of this session of the House of Delegates, the President and the President-Elect each will present his address.)

Monday, May 8—3:15 p.m.

Third Session (Part I)

Reports of Reference Committees

Tuesday, May 9—9:00 a.m.

Third Session (Part II)

Reports of Reference Committees

Unfinished Business

Adjournment

OFFICES TO BE FILLED BY ELECTION—1972 ANNUAL MEETING

Office	Term	From To	Incumbent and County
President-Elect	1 year	May 1972-May 1973	William J. D'Elia Monmouth
1st Vice-President	1 year	May 1972-May 1973	Matthew E. Boylan Hudson
2nd Vice-President	1 year	May 1972-May 1973	James A. Rogers Passaic
Secretary	1 year	May 1972-May 1973	Louis F. Albright Monmouth
Treasurer	1 year	May 1972-May 1973	Samuel J. Lloyd Mercer
Trustees:			
1st District	3 years	May 1972-May 1975	Robert C. Anderson Essex
1st District	3 years	May 1972-May 1975	Edward G. Bourns Union
2nd District	3 years	May 1972-May 1975	Charles L. Cunniff Hudson
2nd District	3 years	May 1972-May 1975	Richard E. Lang Passaic
3rd District	3 years	May 1972-May 1975	George E. Barbour Somerset
3rd District	3 years	May 1972-May 1975	David Eckstein Mercer
4th District	3 years	May 1972-May 1975	I. Edward Ornaf Camden
Judicial Councilors:			
1st District	3 years	May 1972-May 1975	Thomas S. P. Fitch Union

Office	Term	From To	Incumbent and County
4th District	3 years	May 1972-May 1975	Frederick W. Durham Camden
AMA Delegates:	2 years	Jan. 1973-Dec. 1974	†George L. Benz Essex
	2 years	Jan. 1973-Dec. 1974	Frank J. Hughes Camden
	2 years	Jan. 1973-Dec. 1974	John F. Kustrup Mercer
	2 years	Jan. 1973-Dec. 1974	Luke A. Mulligan Bergen
AMA Alternate Delegates:	2 years	Jan. 1973-Dec. 1974	Louis F. Albright Monmouth
	2 years	Jan. 1973-Dec. 1974	John J. Bedrick Hudson
	2 years	Jan. 1973-Dec. 1974	Nicholas A. Bertha Morris
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	1973 Annual Meeting	Albert F. Moriconi Mercer
Alternate	1 year	1973 Annual Meeting	Josiah C. McCracken, Jr. Atlantic
Connecticut:			
Delegate	1 year	1973 Annual Meeting	Warren H. Knauer Union
Alternate	1 year	1973 Annual Meeting	Gastone A. Milano Atlantic
Administrative Councils:			
Legislation:			
5th District	3 years	May 1972-May 1975	John S. Madara Salem
6th Member	3 years	May 1972-May 1975	Winton H. Johnson Bergen
Medical Services:			
5th District	3 years	May 1972-May 1975	David R. Brewer, Jr. Gloucester
6th Member	3 years	May 1972-May 1975	David Flinker Burlington
Mental Health:			
3rd District	3 years	May 1972-May 1975	Robert S. Garber Somerset
6th Member	3 years	May 1972-May 1975	Evelyn P. Ivey Monmouth
Public Health:			
5th District	3 years	May 1972-May 1975	Robert G. Salasin Cape May
6th Member	3 years	May 1972-May 1975	Francis E. Rieman Hudson
Public Relations:			
2nd District	3 years	May 1972-May 1975	Frank R. Begen Bergen
5th District	3 years	May 1972-May 1975	*Josiah C. McCracken, Jr. Atlantic
Standing Committees:			
Annual Meeting	3 years	May 1972-May 1975	Robert E. Verdon Bergen
Finance and Budget	3 years	May 1972-May 1975	▪Louis G. McAfoos, Jr. Camden
Medical Defense and Insurance	1 year	May 1972-May 1973	**William J. D'Elia Monmouth
	3 years	May 1972-May 1975	Paul J. Kreutz Union
Medical Education	1 year	May 1972-May 1973	†John R. Wolgamot Burlington
	3 years	May 1972-May 1975	Edward H. Weiser Sussex
Publication	3 years	May 1972-May 1975	*George B. Sharbaugh Mercer
Woman's Auxiliary Advisory	3 years	May 1972-May 1975	William J. Roe Bergen

* Ineligible for re-election, having served 3 consecutive terms.
▪ Must be member of 1972 House.
** Resigned—Vacancy to be filled by 1972 House.
† Appointed by Board until 1972 Annual Meeting.

1972 Annual Meeting

SPEAKERS

Saturday through Tuesday
May 6 to 9, 1972

Chalfonte-Haddon Hall
Atlantic City

Apolito, Arnaldo, M.D., Montclair
Auerbach, Robert, M.D., New York
Ayres, Stephen M., M.D., New York

Barad, Gerald S., M.D., Flemington
Bahrman, S. Jan, M.D., Ann Arbor
Belmont, Owen, M.D., Philadelphia
Bowe, John J., M.D., Ridgewood
Burks, William P., M.D., Princeton
Butler, Herbert, M.D., Woodbury
Byrne, Richard J. R., M.D., Morristown

Cagan, Macyln, M.D., Rahway
Carmichael, Paul A., M.D., Lansdale, Pa.
Connolly, Henry A., Jr., M.D., Summit

DePalma, Anthony F., M.D., Newark
Diener, Samuel, M.D., East Orange
Dolan, Jerome A., M.D., Paterson

Fadil, Richard, M.D., Passaic
Ferrari, Herbert A., M.D., Summit
Firtel, Saul I., M.D., Livingston
Foord, Edward, M.D., Burlington

Gehring, David A., M.D., Woodbury
Gettes, Bernard C., M.D., Philadelphia
Goldsmith, Lee S., M.D., New York
Good, Robert A., M.D., Minneapolis
Griswold, Merton, M.D., Plainfield
Groisser, Victor W., M.D., Montclair

Hedley-Whyte, John, M.D., Boston
Heller, George, M.D., Englewood
Hodgkinson, C. Paul, M.D., Detroit

Kramer, Lawrence F., Trenton
Kunderman, Philip J., M.D., New Brunswick

Layman, William A., M.D., Hackensack
Lazaro, Eric J., M.D., Newark
Likoff, William, M.D., Philadelphia

Manley, Donelson R., M.D., Philadelphia
Marchesano, Joseph M., M.D., Bloomfield

Naclerio, Emil A., M.D., New York
Nardi, George L., M.D., Boston

O'Rourke, Franklyn S., M.D., Livingston

Palmer, Eddy D., M.D., Newark
Parsonnet, Victor, M.D., Millburn
Pineda, Albert A., M.D., Clifton
Popkin, George L., M.D., Bethpage, N.Y.

Riva, H. L., M.D., Short Hills
Rolnick, Jerome J., M.D., New Brunswick
Rosen, Mortimer G., M.D., Rochester
Rush, Benjamin F., Jr., M.D., Newark

Safir, Aran, M.D., New York
Schatman, Benjamin H., M.D., Millburn
Schlossman, Howard H., M.D., Englewood
Segal, Bernard L., M.D., Philadelphia
Selikoff, Irving J., M.D., Paterson
Sherk, Henry H., M.D., Camden
Smith, A. Marshall, M.D., New Brunswick
Solomon, Sheldon D., M.D., Marlton
Sweeney, William A., M.D., New Brunswick
Swerdlow, Dave B., M.D., Plainfield

Thron, Leopold E., M.D., Paterson
Tsavaris, Louis J., M.D., Newark

Vallis, Charles P., M.D., Lynn, Mass.

Wagman, Edward, M.D., Paramus
Warren, Kenneth W., M.D., Boston
Wilkinson, Lawrence, M.D., Ridgewood
Wolfson, Edward A., M.D., Newark
Wood, William L., M.D., Red Bank

1972 Annual Meeting

SCIENTIFIC SECTION OFFICERS

Saturday through Tuesday
May 6 to 9, 1972

Chalfonte-Haddon Hall
Atlantic City

Allergy

CHAIRMAN—J. Loren Rosenberg, M.D., East Orange
SECRETARY—Arthur Forst, M.D., North Caldwell

Anesthesiology

CHAIRMAN—Henry A. Connolly, Jr., M.D., Summit
SECRETARY—H. A. Ferrari, M.D., Summit

Cardiovascular Diseases

CHAIRMAN—Joel E. Cannilla, M.D., Mountain Lakes
SECRETARY—Harry A. Roselle, M.D., Englewood

Chest Diseases

CHAIRMAN—A. Marshall Smith, Jr., M.D., New Brunswick
SECRETARY—Albert Mintzer, M.D., Elizabeth

Clinical Pathology

CHAIRMAN—Lawrence Wilkinson, M.D., Ridgewood
SECRETARY—Martin J. Salwen, M.D., Long Branch

Dermatology

CHAIRMAN—Roger H. Brodkin, M.D., Irvington
SECRETARY—James T. Vail, Jr., M.D., Summit

Gastroenterology and Proctology

CHAIRMAN—Sydney S. Pearl, M.D., Elizabeth
SECRETARY—Harry B. McCluskey, M.D., Short Hills

General Practice

CHAIRMAN—Daniel N. Burbank, M.D., Cedar Grove
SECRETARY—Edward H. Weiser, M.D., Sussex

Medicine

CHAIRMAN—David A. Gehring, M.D., Woodbury
SECRETARY—James G. Kehler, Jr., M.D., Woodbury

Obstetrics and Gynecology

CHAIRMAN—Jerome A. Dolan, M.D., Paterson
SECRETARY—Ralph H. Van Meter, M.D., Moorestown

Ophthalmology

CHAIRMAN—Raymond E. Adams, M.D., Cherry Hill
SECRETARY—Donald A. Fonda, M.D., Ridgewood

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CHAIRMAN—Walter Schwarzchild, M.D., Cherry Hill
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Urology

CHAIRMAN—Robert E. Fullilove, Jr., M.D., Newark
SECRETARY—Richard Fadil, M.D., Passaic

1972 Annual Meeting

MOTION PICTURE THEATER

Saturday, May 6	2 p.m.
Sunday, May 7	10 a.m. and 2 p.m.
Monday, May 8	10 a.m. and 2 p.m.

Arranged and presented through the cooperation of Roche Laboratories, Division of Hoffmann-LaRoche, Inc., Nutley.

10:00 a.m. and 2:00 p.m.

Differential Diagnosis of Parkinsonism

E. Richard Blonsky, M.D.

Since the introduction of potent chemotherapeutic agents in the treatment of Parkinson's disease, it has become important to differentiate this syndrome from others which mimic it in various ways. Typical Parkinson patients are contrasted with others who display heightened muscle tone, bradykinesia, or various types of tremors. The features which distinguish Parkinsonism are clearly emphasized.

(Presented through the courtesy of Eaton Laboratories)

10:15 a.m. and 2:15 p.m.

Psychiatric Technics for the Family Doctor

Robert Matthews, M.D., Professor of Psychiatry, Jefferson Medical College, and B. Wheeler Jenkins, M.D., Philadelphia

Dr. Matthews discusses the role of the general practitioner in treating neuropsychiatric patients. Dr. Jenkins, a generalist, interviews three patients with various mental difficulties, with written comments by Dr. Matthews superimposed.

(Presented through the courtesy of Ciba Pharmaceutical Company)

11:15 a.m. and 3:15 p.m.

Treatment of Parkinsonism with Levodopa

George W. Paulson, M.D.

Parkinsonism is an old disease, with major manifestations of rigidity, akinesia, and tremor. This film depicts these features and briefly discusses the historical and biochemical impact and relevance of Levodopa. The side effects of dyskinesia are illustrated in one patient and other major side effects of the medication are briefly reviewed.

(Presented through the courtesy of Eaton Laboratories)

11:30 a.m. and 3:30 p.m.

Attorney/Physician-Cooperation in the Defense of Medical Malpractice Cases

The interaction which must take place between a physician and his attorney when he is being threatened with a medical malpractice suit is demonstrated in this film. To illustrate this, a role-playing situation is set up based on an actual midwest case. Robert Carter, who was Professor of Pediatrics at the University of Iowa College of Medicine, acts as the physician being sued and Ronald Carlson, Professor of Law, University of Iowa College of Law, portrays the attorney.

(Presented through the courtesy of Roche Laboratories)

New Jersey Medical Women's Association

Sunday, May 7, 1972 — 11:00 a.m.

Tower Room, Tower Floor, Haddon Hall

Brunch Meeting

Career Women — B.P.W. — "Fewer Flowers Oftener"

Mary Carriero, Florist

1972 Annual Meeting

SCIENTIFIC PROGRAM

Sunday, May 7
Monday, May 8

Scientific Session
Sessions

Scientific Section Sessions

Sunday Morning, May 7

Allergy
Otolaryngology
Pediatrics

(Cosponsored by the New Jersey Allergy Society, the New Jersey Academy of Ophthalmology and Otolaryngology, and the New Jersey Chapter, American Academy of Pediatrics)

9:00 a.m. Symposium on Tonsillectomy-Adenoidectomy and Otitis Media

Treatment of Otitis Media, A Statistical Study
GEORGE HELLER, M.D., Consultant in Pediatrics, Englewood Hospital, Englewood

Based on a study of all cases of otitis media in children cared for during four decades of pediatric practice, the speaker concludes that myringotomy is usually unnecessary and may be hazardous, that antibiotic therapy is safe and effective, and that tonsillectomy is of no preventive value. It is doubtful whether decongestants, analgesic ear drops, or adenoid removal are helpful. A rational therapeutic regimen is presented.

Current Treatment—Will It Be Changed in View of New Immunologic Information?
WILLIAM L. WOOD, M.D., Director, Department of EENT, Riverview Hospital, Red Bank, and President, New Jersey Academy of Ophthalmology and Otolaryngology

The careful selection of patients for adeno-tonsillectomy is further complicated by consideration of the allergic individual.

The immunologic role of local lymphoid tissue is well recognized. However, bacterial sensitivity, together with the aggravating effect of infection on allergic reactions, necessitates the eradication of primary foci of infection.

The indiscriminate removal of tonsil and adenoid tissue is as harmful as the absolute denial of the benefits of surgery. Guidelines are therefore presented for the evaluation of patients with pertinent upper respiratory problems, for it is only through judicious medical and surgical management, as a total care concept, that the patient will receive maximum benefit.

An Allergic Appraisal of the Tonsil, Adenoid, and Otitis Problems
MACLYN CAGAN, M.D., Associate in Pediatric Allergy, Saint Michael's Medical Center, Newark, and Clinical Associate Professor, Pediatrics-Allergy, New York Medical College, New York

Symptoms such as rhinorrhea, cough, wheeze, and so on may be due to infection or allergy or both. Seasonal symptoms may be produced by perennial antigens. Provocative testing for foods and chemicals may help resolve this problem. Recurrence or persistence of symptoms suggests needs for allergic appraisal. Postponement of surgical intervention until allergy is excluded is emphasized.

Development, Diseases, and Reconstruction of the Immunologic System
ROBERT A. GOOD, M.D., Professor and Chairman, Department of Pathology, and Regents Professor of Pediatrics, University of Minnesota Medical School, Minneapolis

Studies defining relations between structure and function in the lymphoid system have been carried out in our clinic and laboratory for 30 years. Interplay between the clinic and experiments, in ontogenetic and phylogenetic perspective, has permitted us to understand the cellular immunity system in terms of two separate immunologic systems, T-cell and B-cell. Primary genetically determined and secondary immunodeficiencies can be incisively viewed in this perspective. Correction by thymic transplant of thymic deficiency in experimental animals, mice thymic deficient on genetic basis, and humans with DiGeorge syndrome has been possible. Severe dual system immunodeficiencies are correctable by transplants with marrow from a sibling donor. These efforts, which have included switching blood type, represent the beginnings of cellular engineering. The immunodeficiencies associated with lymphoreticular malignancies will be dissected in the same way.

11:00 a.m. Panel Discussion

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

12:30 p.m. Luncheon—New Jersey Chapter, American Academy of Pediatrics

Reservations: William C. Ellis, M.D.
279 Third Avenue
Long Branch 07740

Sunday Morning, May 7

Ophthalmology

(Cosponsored by the New Jersey Academy of Ophthalmology and Otolaryngology)

9:00 a.m. Symposium on Contemporary Refraction

Modern Office Procedures
PAUL L. CARMICHAEL, M.D., Associate Surgeon, Wills Eye Hospital, Philadelphia

From an academic standpoint, the subject of refraction involves knowledge and understanding of optical principles as applied to the eye. In a busy ophthalmologic practice it is often not possible to apply scientific principles as specifically as we would like to the examination. A scheme is offered to aid the individual ophthalmologist in the performance of accurate retinoscopy and manifest refraction with satisfaction to the patient and benefit to the ophthalmologist.

Pediatric Refraction
DONELSON R. MANLEY, M.D., Associate Director, Department of Pediatrics and Ocular Motility, Wills Eye Hospital, and Associate Professor of Ophthalmology, Temple University Health Sciences Center, Philadelphia

Summary not received

Management of Aphakia
OWEN BELMONT, M.D., Associate Surgeon, Wills Eye Hospital, Philadelphia

Management of aphakia should begin before operation. Visual efficiency is more than a number, and some patients with cataracts are best left alone.

Aphakes contend with magnification, faulty depth perception, constricted visual field, retinal rivalry and diplopia, spherical aberration and the Jack-in-the-box phenomenon.

Aphakic spectacles are thick and heavy and fitted precisely. Little margin for error exists in lens centering. Aspheric lenses reduce spherical aberration and widen visual field. Vertex distance is important in lenses stronger than 5 diopters. Contact lenses reduce magnification, increase visual field, and allow simultaneous use of the eyes in surgical aphakia.

Future Technics of Refraction
ARAN SAFIR, M.D., Associate Professor of Ophthalmology, Mount Sinai School of Medicine, CUNY, New York

A brief description is given of the appearance and mode of operation of the Ophthalmetron. Typical printouts are shown. Results of clinical trials are reported. These demonstrate that paramedical technicians, trained to do automatic objective refraction with the Ophthalmetron, can successfully perform much of the work of refraction of both adults and children. Applications of these technics to office practice, health maintenance organizations, and mass vision screening programs are discussed.

11:00 a.m. Panel Discussion and Questions

Moderator: BERNARD C. GETTES, M.D., Attending Surgeon and President of Medical Staff, Wills Eye Hospital, Philadelphia

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

12:30 p.m. Luncheon—New Jersey Academy of Ophthalmology and Otolaryngology

Reservations: Raymond E. Adams, M.D.
5 Split Rock Drive
Cherry Hill 08034

Sunday, May 7 (All Day)

Medicine
Cardiovascular Diseases
Radiology

(Cosponsored by the New Jersey Chapter, American College of Emergency Physicians; New Jersey Chapter, American College of Cardiology; New Jersey Society of Internal Medicine; and New Jersey Chapter, American College of Physicians)

9:30 a.m. Diagnosis and Treatment of Acute Drug Reactions
EDWARD A. WOLFSON, M.D., Vice Chairman, Associate Professor, and Director, Division of Drug Abuse, Department of Preventive Medicine and Community Health, College of Medicine and Dentistry of New Jersey, Newark

Rapid diagnosis and effective treatment of acute adverse reactions to the commonly abused drugs is dependent upon knowledge of social and pharmacologic factors, in addition to an understanding of a practical clinical classification of the drugs and the problems resulting from deceptions in the illicit drug market.

Crisis Intervention in the drug scene primarily demands adherence to the A.B.C.'s—maintenance of Airway, Breathing, and Cardiovascular integrity. The only specific antidotes against the commonly abused drugs are the narcotic antagonists for respiratory depression; among other presenting signs and symptoms, only convulsions, arrhythmia, and profound hypertension, regardless of etiology, require prompt chemical intervention.

10:00 a.m. Emergency Diagnosis and Treatment of Cardiac Arrhythmias
BERNARD L. SEGAL, M.D., Clinical Associate Professor of Medicine, Hahnemann Medical College, Philadelphia

Experiences gained through monitoring and managing patients in CCU have revolutionized our knowledge about the recognition and early treatment of life-threatening arrhythmia. The premature ventricular beat, salvos of PUC's, and multifocal PUC's may engender ventricular tachycardia. Antiarrhythmic agents or a combination of drugs are useful in saving lives. Indications of pacing will be discussed in the patient with brady and tachyarrhythmias.

10:30 a.m. Emergency Treatment of Acute Chest Trauma
EMIL A. NACLERIO, M.D., Department of Surgery, Harlem Hospital Center, New York

Summary not received

11:00 a.m. Survival of the Private Practice Concept in the Face of Prepaid Health Care
LEE S. GOLDSMITH, M.D., L.L.B., Special Counsel to the Association of Physicians of French and Polyclinic Hospitals, New York

During the past year 12 different proposals were presented to Congress for establishment of prepaid group practice. This legislative activity is based on a widely held feeling that prepaid group practice is the only method of controlling medical care costs.

Physicians will either take the initiative in formulating and innovating new programs or else find themselves salaried employees. Costs are the focal point while control is the end result.

11:30 a.m. Business Meetings—Election of Officers (Section on Medicine; Section on Cardiovascular Diseases)

Visit to Exhibits

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12 noon **Joint Luncheon—New Jersey Chapter, American College of Cardiology; New Jersey Society of Internal Medicine; and New Jersey Chapter, American College of Physicians**

Reservations: Joel E. Cannilla, M.D.
6 Hinchman Avenue
Denville 07834

1:00 p.m. Coronary Angiography in the Community Hospital

Moderator: William Likoff, M.D., Chairman, Postgraduate Education Program, American College of Cardiology, Philadelphia

JEROME J. ROLNICK, M.D., Director, Cardiopulmonary Laboratory, Saint Peter's General Hospital, New Brunswick; and Clinical Assistant Professor of Medicine, Rutgers Medical School, CMDNJ, Piscataway

and

WILLIAM A. SWEENEY, M.D., Director, Department of Radiology, Saint Peter's General Hospital, New Brunswick; and Clinical Assistant Professor of Radiology, Rutgers Medical School, CMDNJ, Piscataway

The role of the community hospital in coronary angiography has been the subject of considerable debate. Those who feel the procedure should not be done at the community hospital level cite the absence of an open heart surgical team, mortality and morbidity, a repetition of study, and even creditability of data when the procedure is done outside the larger medical centers.

Data will be presented here reviewing the three years experience of coronary arteriography at St. Peter's Hospital in New Brunswick. The above arguments are considered and challenged and the usefulness of such a procedure to the community and to its practicing physicians is emphasized.

2:00 p.m. Surgical Aspects of Coronary Artery Disease
VICTOR PARSONNET, M.D., Director of Surgery, Newark Beth Israel Medical Center, Newark; and Clinical Professor of Surgery, College of Medicine and Dentistry of New Jersey, Newark

Direct surgery of the coronary arteries is clearly indicated for certain types of coronary heart disease, particularly the impending infarction syndrome, incapacitating angina, and certain cases of complications of myocardial infarction. Wide acceptability of this technic has been delayed by reports of vein graft closure in approximately 20 per cent of cases. It is probable that closure of vein grafts is due to poor selection of cases, faulty anastomotic methods, and inadequate runoff in the coronary arteries. In the early stages, obliteration of the vein due to intimal proliferation will rarely be a cause of graft failure. Clinical evidence for these contentions will be demonstrated.

2:30 p.m. Complications of Cardiovascular Angiography
RICHARD J. R. BYRNE, M.D., Department of Radiology, Morristown Memorial Hospital, Morristown; and Assistant Professor of Radiology, College of Medicine and Dentristry of New Jersey, Newark

A brief history and review of current technics in performing angiocardiography will be given, followed by a discussion of complications, with specific cases illustrated by slides. Past, present, and expected morbidity and mortality rates will be considered and related to performance of angiocardiography, both in referral centers and the community hospital.

3:00 p.m. Business Meeting—Election of Officers (Section on Radiology)

3:15 p.m. Annual Meeting—New Jersey Society of Internal Medicine

Visit to Exhibits

Sunday Afternoon, May 7

Anesthesiology

(Cosponsored by the New Jersey State Society of Anesthesiologists)

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12 noon **Luncheon—New Jersey State Society of Anesthesiologists**

Reservations: NJSSA
Atttention: Miss Palma
180 East 21st Street
Paterson 07513

1:00 p.m. **Current Concepts in Acute and Chronic Respiratory Care**

Moderator: HENRY A. CONNOLLY, JR., M.D., Chief of Anesthesiology, Overlook Hospital, Summit

Panelists: STEPHEN M. AYRES, M.D., Director, Cardiopulmonary Department, Saint Vincent's Hospital; and Associate Professor of Clinical Medicine, NYU School of Medicine, New York
and
JOHN HEDLEY-WHYTE, M.D., Anesthetist-in-Chief, Beth-Israel Hospital, Boston

Acute respiratory failure may result from exacerbation of chronic airway obstructive disease or from some acute process occurring in a patient with previously normal lungs or with mild respiratory disease. Patients with chronic airway obstructive disease are frequently adapted to low-oxygen and high-carbon dioxide tensions. In contrast, rapid changes in oxygen tension and acid-base balance develop in patients with acute respiratory failure and previously normal lungs. Acute respiratory failure with previously normal lungs is best termed "nonobstructive respiratory failure" or the "stiff-lung" syndrome. Treatment for all varieties of respiratory failure involves correction of respiratory gases by either oxygen administration or ventilatory assistance. Metabolic abnormalities must be corrected by appropriate technics.

2:30 p.m. **Discussion—Discussor:** HERBERT A. FERRARI, M.D., Director, Department of Anesthesiology, Jersey City Medical Center, Jersey City

3:00 p.m. **Business Meeting—Election of Officers**

Visit to Exhibits

Visit The Exhibits

Informational

Scientific

Technical

Sunday Afternoon, May 7

Psychiatry and Neurology

(Cosponsored by the New Jersey Neuropsychiatric Association and the New Jersey Psychoanalytic Society)

1:00 p.m. **Symposium: The Interface Between Psychiatry and Other Branches of Medicine**

Severe Depression Resembling Severe Physical Illness
ARNALDO APOLITO, M.D., Clinical Assistant, The Mountainside Hospital, Montclair; and Assistant Clinical Professor of Psychiatry, College of Medicine and Dentistry of New Jersey, Newark

Psychotic depression is easily recognized when it occurs in young people and when a definite mood of profound sadness is apparent. However, in middle age, it may happen that the secondary symptoms of psychotic depression are so outstanding and the patient appears so ill physically, that the change of mood is either not detectable or overlooked. Profound physical debilitation and infection, severe cloudiness of the sensorium, or semicomatose states may suggest a variety of organic diseases. Clinical cases are described and a psycho-physiologic mechanism of these syndromes is suggested.

The Psychological Impact of Coronary Care Units
WILLIAM A. LAYMAN, M.D., Assistant Attending Psychiatrist, Hackensack Hospital, Hackensack; and Associate Professor of Psychiatry, College of Medicine and Dentistry of New Jersey, Newark

The psychological impact of a myocardial infarction and specific treatment in a Coronary Care Unit is a major concern and has many facets.

This paper, by means of personal experience, direct observation, and review of the literature, discusses this psychic trauma and the various ways in which the Coronary Care Unit contributes to or interferes with the patient's emotional rehabilitation.

Lag in Physical Development in Adolescence, Secondary to Psychological Conflict
HOWARD H. SCHLOSSMAN, M.D., Department of Psychiatry, Hackensack Hospital, Hackensack; and Associate Clinical Professor, Albert Einstein College of Medicine, New York

The major psychological conflict in adolescence is concerned with identity. The rapid physiologic and anatomic changes disturb the body image representation with the ego and provoke a sense of danger. In some the emotional response to this anxiety can delay growth and maturation. A theory is offered to explain lowering of hormonal output in these adolescents.

2:30 p.m. **Discussion**

3:00 p.m. **Business Meeting—Election of Officers**

Sunday Afternoon, May 7

Urology

1:00 p.m. Vasectomy—Survey and Symposium
RICHARD FADIL, M.D., Clinical Assistant, College of Medicine and Dentistry of New Jersey, Newark

Summary not received

Motion Picture on Vasectomy Technic

Psychiatric Commentary
LOUIS J. TSAVARIS, M.D., Assistant Professor, Department of Psychiatry, College of Medicine and Dentistry of New Jersey, Newark

Summary not received

2:30 p.m. Discussion

3:00 p.m. Business Meeting—Election of Officers

Visit to Exhibits

Monday Morning, May 8

Chest Diseases
Clinical Pathology

(Cosponsored by the New Jersey Society of Pathologists and the New Jersey Chapter, American College of Chest Physicians)

9:30 a.m. Symposium on Granulomatous Disease of the Lung

Biopsy Procedures
PHILIP J. KUNDERMAN, M.D., Chief, Thoracic and Cardiac Surgical Service, Middlesex General Hospital, New Brunswick

Accurate identification of the nature of a granulomatous lesion of the lung is frequently extremely important in determining treatment and prognosis. To this end, the surgeon is often called upon to establish a definitive diagnosis by submitting suspicious tissue to the discriminating eye of the pathologist. Three principle methods are used: bronchoscopy, mediastinoscopy, and thoracotomy. The indications for and description of these procedures will be reviewed.

Clinical Aspects
IRVING J. SELIKOFF, M.D., Professor and Chairman, Division of Environmental Medicine (Department of Community Medicine), Mount Sinai School of Medicine, CUNY, New York

Summary not received

Histopathology
EDWARD WAGMAN, M.D., Director of Laboratories, Bergen Pines Hospital, Paramus; and Assistant Clinical Professor of Pathology, School of Dentistry, Fairleigh Dickinson University, Teaneck

This paper will concern itself with a discussion of the various histopathologic responses in granulomatous diseases of the chest. There are approximately fifty such disorders found in association with infection, foreign bodies, hypersensitivity reactions, and neoplasm. The cause is unknown in some. The tissue reactions resulting from different agents may be identical. One micro-organism can cause dissimilar responses. Emphasis will be placed on methods to identify these agents so that definitive diagnoses can be made. Cases demonstrating the various histologic patterns will be presented.

11:00 a.m. Panel Discussion
Moderators: A. MARSHALL SMITH, JR., M.D., Chairman, Section on Chest Diseases;
and
LAWRENCE WILKINSON, M.D., Chairman, Section on Clinical Pathology

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

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12 noon Luncheon—New Jersey Chapter, American College of Chest Physicians (Annual Selman A. Waksman Lecture)

Reservations: A. Marshall Smith, Jr., M.D.
374 Livingston Avenue
New Brunswick 08902

Monday Morning, May 8

Dermatology
Plastic and
Reconstructive Surgery

(Cosponsored by the New Jersey Society of Plastic and Reconstructive Surgeons)

9:30 a.m. Surgical Treatment of Baldness by Hair Transplantation
ROBERT AUERBACH, M.D., Associate Professor, Skin and Cancer Unit, New York University School of Medicine, New York

The success of hair transplantation depends on the principle that hair follicles moved from their original location on the body to another area will

grow. In addition to ordinary male pattern baldness, less common types of hair loss resulting from scars, burns, radiation, and systemic diseases can be improved with hair transplants. This applies not only to scalp hair but to eyebrows. The procedure is done with a local anesthetic and consists of moving 4 millimeter composite grafts of skin from the donor area in the posterior scalp to the recipient area. In two to four months hair begins to grow and lasts a lifetime.

10:00 a.m. Hair Transplantation by Strip Grafts
MERTON L. GRISWOLD, M.D., Attending Plastic Surgen, Muhlenberg Hospital, Plainfield
and
CHARLES P. VALLIS, M.D., Instructor in Plastic Surgery, Tufts University; and Attending Plastic Surgeon, Union Hospital, Lynn, Massachusetts

There are certain patients who desire a heavier implantation of hair in the upper forehead than can be achieved with punch grafts alone. For this type of baldness, strip grafts taken from the occipital area make a more satisfactory hairline. Strip grafts by themselves make an uneven hair pattern for extensive bald areas and should be used only as a stage in operative procedures for hair transplantation of the scalp.

10:30 a.m. Dermatological Treatment of Basal Cell Carcinoma

GEORGE L. POPKIN, M.D., Professor of Clinical Dermatology, New York University School of Medicine, New York

Summary not received

11:00 a.m. Surgical Approach to Basal Cell Carcinoma
JOHN J. BOWE, M.D., Attending Surgeon (Plastic), St. Joseph's Hospital, Paterson

The basal cell carcinoma is the most frequently encountered skin neoplasm. While distribution over broad areas of the body are encountered, the greatest concentration of tumors has been found on the head and neck.

The approach to surgical cure of basal cell carcinoma is outlined. The philosophy of surgical removal is stressed and the benefit of careful study of the removed specimen by surgical pathology emphasized.

The plastic surgical repair of operative defects is illustrated and in most cases this can be effected at the time of tumor extirpation.

11:30 p.m. Business Meeting—Election of Officers

Visit to Exhibits

12:30 p.m. Luncheon—New Jersey Society of Plastic and Reconstructive Surgeons

Reservations: Edward N. Ludin, M.D.
State Highway 70 at Madison Avenue
Cherry Hill 08034

Monday, May 8 (All Day)

Obstetrics and Gynecology

(Cosponsored by New Jersey Obstetrical and Gynecological Society)

NOTE: 25th Anniversary Banquet, New Jersey Obstetrical and Gynecological Society will be held on **Sunday, May 7,** at 8:00 p.m.

Guest Speaker: Honorable Lawrence F. Kramer, Commissioner, Department of Community Affairs, State of New Jersey

Reservations: B. Frank Lovett, M.D.
Cooper Parkway Bldg.
Pennsauken 08110

Moderator: JEROME A. DOLAN, M.D., Chairman, Section on Obstetrics and Gynecology; and Director, Department of Obstetrics and Gynecology, St. Joseph's Hospital, Paterson

9:00 a.m. The Impact of Cytologic Screening

ALBERT A. PINEDA, M.D., Adjunct Attending, Department of Obstetrics and Gynecology, St. Joseph's Hospital, Paterson; and Clinical Assistant Professor, Obstetrics and Gynecology, New York Medical College-Metropolitan Hospital Center, New York

With support of the New York City Department of Health and the United States Public Health Service, a cervical cancer detection program was initiated at the New York Medical College—Metropolitan Hospital Center in 1960. A hospital provides an excellent environment for early diagnosis of cervical cancer. Every female patient should receive a pelvic examination with cytologic screening and this can be done without undue patient suspicion or anxiety, particularly in a prenatal clinic. Our screening has led to improvement in the diagnosis of cervical neoplasia, which has had major impact on our oncology program. Since onset of our study in 1960, there has been a definite increase in the number of reported cases of cervical cancer.

Cervical cancer control programs have been directly responsible for the increase of cases detected. Of equal prognostic importance is the earlier stage of detection. Prior to this program, most of the patients had an invasive lesion.

In the latter part of 1965, after we expanded our case detection by the screening of every female admitted to the other services of the hospital, there was a further Increase in Stage 0 and Stage 1 admissions to our tumor service. Review of our records showed a definite Increase In number of patients admitted with diagnosis of cervical cancer but did not reflect any change on the admlssion rate of patients with ovarian, vulval, or vaginal cancers.

We have a multi-disciplinary tumor service—general surgery, gynecology, urology, and radiotherapy.

This has not only improved our ability to treat the increasing number of patients but also has resulted in a comprehensive training program.

Since 1960, subsequent to the formation of our comprehensive cytological screening program, experience has shown that there has been a marked increase in the number of patients and also a decided shift to the in-situ lesions.

9:45 a.m. What's New in Infertility?

S. JAN BEHRMAN, M.D., Professor of Obstetrics and Gynecology and Director, Center for Research in Reproductive Biology, University of Michigan Medical Center, Ann Arbor

Perhaps the most significant areas of improvement and potential therapeutic benefit in the management of cases of infertility could be classified into: (1) diagnosis of cervical mucus and immunologic factors; (2) newer methods of detection of ovulation with variations of induction of ovulation; (3) the freeze preservation of human sperm for artificial insemination; and (4) laparoscopic technics for diagnosis and treatment of problems of infertility. These will all be discussed and highlighted with a short fifteen minute film on the "Laparoscope."

10:30 a.m. Coffee Break

10:45 a.m. What's Ahead in Fetal Monitoring?

MORTIMER G. ROSEN, M.D., Associate Professor and Director of Research, Department of Obstetrics and Gynecology, University of Rochester School of Medicine, Rochester

Fetal monitoring of the heart rate and maternal in utero pressure has become a part of the physician's armamentarium in the management of "at risk" fetuses during labor. There is still a great deal of confusion in the interpretation of these findings. Purpose of this discussion is to point out the present state of the art and some of the new directions it must take to allow the obstetrician to make meaningful clinical decisions in the management of his patient. Material relating to second generation computers, fetal electroencephalography, and infant developmental studies will be presented.

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

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12 noon **Joint Luncheon—New Jersey Obstetrical and Gynecological Society and MSNJ's Section on Obstetrics and Gynecology**

Reservations: B. Frank Lovett, M.D.
Cooper Parkway Building
Pennsauken 08110

Moderator:
LEOPOLD E. THRON, M.D., President, New Jersey Obstetrical and Gynecological Society

1:30 p.m. Stress Urinary Incontinence
C. PAUL HODGKINSON, M.D., Chairman, Department of Gynecology-Obstetrics, Henry Ford Hospital, Detroit

Stress urinary incontinence is the involuntary loss of urine through the intact urethra as the result of a sudden increase in intra-abdominal pressure. Differential diagnosis includes the loss of urine as the result of involuntary voiding from detrusor dyssynergia, as well as incontinence of overflow and urgency incontinence. In this discussion the physiology of normal urethrovesical control in the human female will be reviewed briefly. The urethrovesical relationships of stress urinary incontinence and the alterations effected by various operations will be demonstrated. Finally, reasons for operative failure will be reviewed.

2:15 p.m. Endometriosis: Medical Versus Surgical Management
H. L. RIVA, M.D., Professor of Obstetrics and Gynecology, College of Medicine and Dentistry of New Jersey, Newark.

Summary not received

3:00 p.m. The Great Debate: Fathers in the Delivery Room
Affirmative: GERALD S. BARAD, M.D., Director, Obstetrics and Gynecology, Hunterdon Medical Center, Flemington

Summary not received

Negative: EDWARD FOORD, M.D., Director, Obstetrics and Gynecology, Burlington County Memorial Hospital, Mount Holly

Summary not received

3:45 p.m. Business Meeting—New Jersey Obstetrical and Gynecological Society

Visit to Exhibits

Monday Morning, May 8

Orthopaedic Surgery

(Cosponsored by New Jersey Orthopaedic Society)

9:30 a.m. Experience with Total Hip Replacement Using Methyl Methacrylate Cement at a General Community Hospital
SAUL I. FIRTEL, M.D., Attending in Orthopaedic Surgery, Saint Barnabas Medical Center, Livingston

Summary not received

10:00 a.m. Palliative Use of Cryosurgery for Metastatic Disease of Bone
FRANKLIN S. O'ROURKE, M.D., Attending in Orthopaedic Surgery, Saint Barnabas Medical Center, Livingston

Freezing by either direct application of iiquid nitrogen or by intermedullary probe-guided use has been used to relieve pain and locally destroy metastatic and inoperable primary bone tumors. Although not meant to be a cure, local pain has been relieved and all pathologic fractures have gone into healing. Certain immunologic aspects as well as technics are discussed.

10:30 a.m. Coffee Break

11:00 a.m. Affiliated Orthopaedic Resident Training Programs in New Jersey
ANTHONY F. DEPALMA, M.D., Professor and Chairman, Division of Orthopaedic Surgery, College of Medicine and Dentistry of New Jersey, Newark

Summary not received

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

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12 noon **Luncheon — New Jersey Orthopaedic Society**

Reservations: Saul I. Firtel, M.D.
Saint Barnabas Medical Center
Livingston 07039

Monday Morning, May 8

Surgery

(Cosponsored by New Jersey Chapter, American College of Surgeons, College of Medicine and Dentistry of New Jersey, Newark; Rutgers Medical School, New Brunswick; and the Academy of Medicine of New Jersey, Newark)

8:30 a.m. Registration and Coffee

9:00 a.m. Welcoming Remarks
WILLIAM P. BURKS, M.D., Chairman, MSNJ's Section on Surgery

9:05 a.m. Introductory Remarks
BENJAMIN F. RUSH, JR., M.D., Johnson and Johnson Professor of Surgery, and Chairman, Department of Surgery, College of Medicine and Dentistry of New Jersey, Newark

9:10 a.m. Presentation of Results of Questionnaire
ERIC J. LAZARO, M.D., Professor of Surgery, College of Medicine and Dentistry, Newark

9:15 a.m. A Medical View of Surgical Lesions of the Pancreas
EDDY D. PALMER, M.D., Professor of Medicine, College of Medicine and Dentistry of New Jersey, Newark

Medical attitudes toward the more serious diseases of the pancreas have not changed materially in many years. The internist continues to find the pancreas the most inapproachable of abdominal organs. Management of acute pancreatitis continues to be rather routine and unimaginative. For chronic pancreatitis, supplementation of the deficiencies plus efforts to manage the pain seem to exhaust the therapeutic possibilities. The internist is frightened to find that carcinoma of the pancreas is showing a spectacular increase in prevalance, and yet the therapeutic possibilities continue to be dismal. The internist is afraid that the surgeon has little more to offer the patient with serious pancreatic disease than does the internist.

10:00 a.m. Surgical Management of Pancreatitis
GEORGE L. NARDI, M.D., Clinical Associate Professor of Surgery, Harvard Medical School, Boston

A critical review of the management of acute pancreatitis with emphasis on unusual manifestations of this disease and more aggressive surgical measures will be presented. Discussion of management will consider the role of endocrine changes, anti-enzymes, and surgical therapy. Other aspects of this disease including heredity, hyperlipemia, and trauma will be considered.

10:30 a.m. Coffee Break

10:45 a.m. Benign and Malignant Tumors of the Pancreas
KENNETH W. WARREN, M.D., Chief Consultant in Surgery, Lahey Clinic, Boston

There is continuing controversy regarding the surgical management of periampullary carcinoma and, to a lesser degree, the management of benign tumors of the head of the pancreas in the periampullary area. The pessimism in the literature with respect to this surgical problem is based primarily upon inexperience. In a few centers sufficient experience has been accumulated to bring this readily into focus. The discussion will be devoted to this question.

11:15 a.m. Panel Discussion on Lesions of the Pancreas
Panelists:
GEORGE L. NARDI, M.D.
EDDY D. PALMER, M.D.
KENNETH W. WARREN, M.D.
SAMUEL DIENER, M.D.

11:30 a.m. Business Meeting—Election of Officers

Visit to Exhibits

12:30 p.m. Luncheon — Cosponsoring Organizations
Reservations: Eric J. Lazaro, M.D.
Harrison S. Martland Hospital
65 Bergen Street
Newark 07107

Monday afternoon, May 8

Gastroenterology and Proctology General Practice

(Cosponsored by New Jersey Academy of Family Physicians and New Jersey Proctologic Society)

1:00 p.m. Office Treatment of Common, Painful Anorectal Problems

DAVE B. SWERDLOW, M.D., Section of Colon and Rectal Surgery, The Mountainside Hospital, Montclair

Anorectal problems occur frequently. This area is very sensitive so that pain and discomfort can be incapacitating. Rapid, effective relief from these disorders can be accomplished simply with a minimum of equipment. Office treatments allow the patients relief of symptoms, and a more rapid return to normal activities. If further treatment is indicated, it can be accomplished electively at a more convenient time.

Thrombosed external hemorrhoid, thrombosed internal hemorrhoid, peri-anal abscess, pilonidal cyst abscess, and fissure in ano will be presented. Their emergency office treatment will be suggested.

Further definitive surgery will be suggested where appropriate indications are present.

1:30 p.m. The Dying Patient (dying in the sense of upper GI catastrophy)

VICTOR W. GROISSER, M.D., Director, Department of Gastroenterology, The Mountainside Hospital, Montclair; and Professor of Clinical Medicine, College of Medicine and Dentistry of New Jersey, Newark

Summary not received

2:00 p.m. Current Concepts in the Surgical Management of Bleeding Diverticulitis

BENJAMIN H. SCHATMAN, M.D., Associate Attending in Proctology, Saint Barnabas Medical Center, Livingston; and Assistant Professor of Surgery, College of Medicine and Dentistry of New Jersey, Newark

Summary not received

2:30 p.m. Discussion

3:00 p.m. Business Meeting—Election of Officers

Monday afternoon, May 8

Rheumatism

1:00 p.m. Symposium on Arthritis
Juvenile Rheumatoid Arthritis

JOSEPH MARCHESANO, M.D., Director of Rheumatology, College of Medicine and Dentristry of New Jersey, Newark; and Director, Arthritis Diagnostic Section, Children's Specialized Hospital, Westfield

Summary not received

Arthritis as a Manifestation of Various Disease States

SHELDON D. SOLOMON, M.D., Co-Director, Rheumatology Clinic, The Cooper Hospital, Camden

Arthritis and musculoskeletal complaints are often the reason for patients first seeking the advice of their physician. Frequently, however, their complaints reflect disorders primarily of other systems —hemotologic, endocrinologic, dermatologic, and so on. These disorders often have distinct patterns of arthritis coupled with extra-rheumatic symptoms. By defining the patterns that these disorders present, the clinician will more easily be able to determine the underlying cause. Examples will be discussed. It is no longer enough to inform the patient that he has arthritis and "should learn to live with it."

Orthopedic Surgery for the Arthritic Patient

HENRY H. SHERK, M.D., Chief of Orthopedics, The Cooper Hospital, Camden; and Assistant Professor of Orthopedics, The University of Pennsylvania Medical School and Hospital, Philadelphia

If the rheumatologist decides that his patient is not improving satisfactorily with the medications and physical therapeutic measures available, he may elect to supplement his program with surgery. The operations that are applicable to such a circumstance are: (1) synovectomy, (2) arthoplasty, (3) osteotomy, and (4) fusion.

The selection of the procedure depends on (1) the state of the disease—early versus late, (2) the extent of the disease—the number of joints involved and the combination of involvement, and (3) the goals of treatment ranging from slight functional improvement in a wheel chair patient to restoration to a full active life.

3:15 p.m. Business Meeting—Election of Officers

VISIT THE EXHIBITS

1972 Annual Meeting

INFORMATIONAL EXHIBITS

Saturday, May 6—12 noon to 5 p.m.
Sunday, May 7—9 a.m. to 5 p.m.
Monday, May 8—8:30 a.m. to 5 p.m.

Children's Seashore House

Atlantic City

Children's Seashore House is dedicated to short term, intensive rehabilitation of children with physical handicaps and chronic illness. This is the oldest institution of its kind in the United States (1872-3). We emphasize the total approach to the child, his or her family, and environment. Toward this end we have, as part of our team, physicians, consultants, nursing-child care, play therapist, school teachers, speech, physical, and occupational therapists, clinical psychologists, and psychiatrists. Details will be shown in our exhibit slide presentation at the booth.

Dairy Council of Northern New Jersey A Day of Growth

East Orange

"A Day of Growth" depicts various health routines throughout the day. Shown are washing, eating, playing, and sleeping. By putting emphasis on eating a variety of foods, mental and physical stimulation, social interaction, and emotional well-being, the exhibit encourages healthy living habits.

Environmental Health

MSNJ's Special Committee on Environmental Health

The exhibit will consist of film strips, photos, and posters dealing with environmental health.

The Family Practice Residency Program at Hunterdon Medical Center

Flemington

Here is a narrative history of Hunterdon Medical Center and a list of graduates of the training program, with their current status. Included is a pictorial history of training programs for family practice at Hunterdon Medical Center since 1953. A map of Hunterdon County is shown with a picture of the hospital, satellite centers, and family doctors' offices superimposed. The theme is that education for residents and continuing education for MD's has an interface at the hospital.

Health Maintenance Organizations: Concepts, Development, and Function

New Jersey State Department of Health, Trenton

The purpose of this display is to inform physicians as to the nature, function, and development of a technic for prepaid group medical practice. The exhibit will show the principles of organization and operation, including start-up costs and legal implications. The conclusions are that delivery of health care by this method deserves careful consideration by all physicians.

Infectious Disease Services for the Practitioner

Saint Michael's Medical Center, Newark

The purpose of this exhibit is to familiarize the busy practitioner with the free information service on antibiotics, vaccines, and special infectious disease problems. This is an information phone service which has been in existence for the past seven years for physicians of New Jersey.

We also provide a special service for the practitioner who has a patient with fever of unknown origin and has exhausted all local resources. The service includes free consultations with the infectious disease group of the New Jersey College of Medicine and Saint Michael's Medical Center, plus the expertise of seven major infectious disease laboratories in the United States. This exhibit reflects the experience of the phone information service and the "fever of unknown origin" service and how it has been useful for the practitioner.

Morris Hall Health and Rehabilitation Center

Lawrenceville

Morris Hall Health and Rehabilitation Center is a 206-bed special hospital for rehabilitation and post-hospital extended care. It is located on Route 206 in Lawrenceville, between Trenton and Princeton. The exhibit shows pictures illustrating facilities and has available a brochure for distribution explaining the Center in more detail.

New Jersey Community Study on Pesticides

New Jersey State Department of Health, Trenton

A continuing study is displayed of the possible long-term effects of pesticides on human health. Acute poisonings are also studied insofar as clues may be provided for further study. There is a need to determine the effects of single and mixed pesticide intakes, for effects of potentiation or antagonism.

Occupational groups exposed to pesticides are under study, and some are found to be under greater health risk.

The project will now undertake a broader health survey in this area, in order to provide morbidity statistics related to pesticides.

Printed material which may be of interest to physicians, giving diagnostic and therapeutic information, is made available.

New Jersey Health Services Program (Medicaid)

New Jersey State Department of Institutions and Agencies, Trenton

This is an informational service booth on Medicaid. In addition to charts and graphs, there will be present a professional (physician) and administrative representative, as well as a representative of the contractor, the Prudential Insurance Company, to field any questions in reference to the Medicaid Program.

Home Health Agency Assembly

New Jersey League for Nursing, Red Bank

Brochures explaining the services of the various agencies will be available.

New Jersey Regional Medical Program

East Orange

The exhibit briefly explains the purpose of the New Jersey Regional Medical Program and describes its accomplishments and activities in heart disease, cancer, stroke, renal, and related diseases.

Senior Citizen Comprehensive Health in Middlesex County

Roosevelt Hospital, Edison

Here is a survey of services, results obtained, and prospective services. Also shown are illustrations of the functions of a County Hospital in the health field under the direction of a County Board of Freeholders and Citizens' Advisory Committee.

Woman's Auxiliary to the Medical Society of New Jersey

Trenton

Displayed here is material depicting the purposes and accomplishments of the Auxiliary. Pamphlets and information concerning membership are available. Non-members may enroll at this booth.

RECEPTION

Saturday, May 6, 1972

Cocktails-Buffet

Dancing

(Tickets at Registration Desk)

DINNER-DANCE

Monday, May 8, 1972

Entertainment

Dancing

(Tickets at Registration Desk)

The Medical Society of New Jersey Welcomes the Following Delegates and Guests

Connecticut	E. Tremain Bradley, M.D., Norwalk
Maryland	DeWitt E. DeLawter, M.D., Bethesda
Pennsylvania	George P. Rosemond, M.D., Philadelphia

1972 Annual Meeting

SCIENTIFIC EXHIBITS

Saturday, May 6—12 noon to 5 p.m.
Sunday, May 7—9 a.m. to 5 p.m.
Monday, May 8—9 a.m. to 5 p.m.

Duodenal Fixation Anomalies S-101

Diller B. Groff, M.D., College of Medicine and Dentistry of New Jersey at Newark; Anita Falla, M.D. and James Marquis, M.D., Children's Hospital of Newark

Through sound (earphones) movies, methods of diagnosis and treatment of duodenal fixation anomalies are described. The importance of cinefluorography is emphasized in diagnosis and the essential steps in surgical correction in infants are illustrated. Findings and the results of treatment in 28 patients are tabulated.

Argon Laser Photocoagulation of Retinal Disease S-102

Nicholas C. Trotta, M.D., Saint Barnabas Medical Center, Livingston

Purpose of the exhibit is to show the effectiveness of Argon Laser coagulation in the treatment of retinal diseases such as tears, Bruch's Membrous Syndromes, macula edema, diabetic retinopathy, and other neovascular retinal diseases.

Photocoagulation of Diabetic Retinopathy and Other Vascular Diseases of the Retina S-103

John C. Leaman, M.D. and A. A. Cinotti, M.D., United Hospitals of Newark, Eye and Ear Division; and College of Medicine and Dentistry of New Jersey at Newark

Illustrated are diagnosis and treatment of diabetic retinopathy and other vascular diseases of the retina. The use of the Argon Laser and other modalities of photocoagulation in conjunction with intravenous fluorescein angiography will be stressed. Results will be described with photographs.

Diagnostic Mini-Lap for Unexplained Jaundice S-104

Louis R. M. DelGuercio, M.D. and William E. Mattey, M.D., Saint Barnabas Medical Center, Livingston

The Mini-lap is an integrated procedure, consisting of transhepatic cholangiography, liver biopsy, and omentoportography, performed under local anesthesia through a 5-cm subxiphoid incision. This was used in patients with hepatobiliary disorders who presented major diagnostic or therapeutic problems. Diagnosis was achieved in all cases. The frequency of two of the three major complications that occurred should be reducible by suture ligation of puncture sites. There were no deaths attributable to the procedure. Coagulation abnormalities may coexist, but the only recognizable contraindication is sensitivity to contrast medium.

The Mini-lap is an effective method of resolving puzzling cases of hepatobiliary disease and should save much time and expense. It has also been helpful in the planning and carrying out of surgery for biliary obstruction and portal hypertension.

Microneurosurgery—Patient Care and Teaching S-105

Kenneth Shulman, M.D. and Ronald I. Apfelbaum, M.D., Albert Einstein College of Medicine, Bronx, New York

The exhibit demonstrates the use of closed circuit television in microvascular neurosurgery, particularly in the treatment of aneurysms of the circle of Willis and deeply placed tumors. In addition to its use during surgery, videotaping permits playback for teaching of the procedures and improvement of technic.

A Medical Student Community Health Program for the High-Risk Child S-106

Christian M. Hansen, M.D., Rutgers Medical School, CMDNJ, New Brunswick

Indicated here is the role of first and second year medical students in assisting in caring for high-risk, low-income infants and children in a center-city settlement house. The exhibit shows how students, faculty, nurses, and community health workers have combined to provide child health supervision to 375 infants and children during the past year. The exhibit reflects the extent of the problem of lack of child health supervision to poor children in New Brunswick and what this program has done about it. Data on the children and services provided will be available. Attitudes of medical students active in the program and how they feel it has been of value to them in their medical education will be presented. It is concluded that first and second year medical students can play a role in serving the high-risk infant and child. Both benefit from the exposure early in the students' career.

The Odyssey House Method in the Long Term Rehabilitation of the Drug Dependent Person S-107

William R. Edmondson, M.D., Newark

Here is a pictorial display of methods and activities involved in the rehabilitation of drug dependent individuals. A graphic demonstration of our results will also be included.

Pharmacologic Properties and Clinical Uses of Estrogen in the Human S-108

Herbert S. Kupperman, M.D., Iven S. Young, M.D., Julianne Imperato, M.D., and Paul Beck, M.D., New York University, New York

Here is a review of the effects of estrogens in the climacteric, the excessively tall girl, osteoporosis,

functional uterine bleeding, and primary amenorrhea.

An Automatic Portable Cardiac Resuscitation Unit to Prevent Electric Failure of the Heart S-109

Victor P. Satinsky, M.D. and Samuel Williams, Hahnemann Medical College and Hospital, Philadelphia

A fully automatic cardiac monitoring and resuscitation unit has been developed to contend with cardiac electric failure. The unit consists of an ECG preamplifier which activates a monostabile multivibrator which in turn generates a square wave for each QRS complex. The square wave is independent of the QRS configuration and is used for further control operations. In the event of asystole for a variable period of 1 to 20 seconds, a 50 joule defibrillator pulse is applied by conventional electrodes to the patient's chest and repeated every five seconds until a spontaneous heart beat returns. In addition, a radio transmitter is activated when the pacing mechanism is operational, thus alerting the hospital of the patient's impending catastrophe. Once the unit has been sufficiently miniaturized it will provide cardiac patients with a portable, fully automatic emergency resuscitation device without loss of mobility or the need for medical personnel. Further, this system will treat potentially fatal cardiac electric failure early in its development, and allow the hospital to monitor numerous patients for cardiac distress without taxing already strained hospital facilities and personnel.

Helium Therapy for the Prevention of Ventricular Fibrillation Following Myocardial Infarction S-110

Victor P. Satinsky, M.D., Robert J. Toltzis, A.B., and Alan G. Toltzis, Hahnemann Medical College and Hospital, Philadelphia

Helium, administered intratracheally, has been used in our laboratory to ascertain its capacity to prevent ventricular fibrillation post-coronary artery ligation. Following occlusion of the anterior descending coronary artery, fourteen (64 per cent) of 22 control dogs developed ventricular fibrillation within two hours. Comparably, 20 dogs were administered a mixture of 20 per cent helium, 30 per cent oxygen, and 50 per cent air — 10 minutes prior to, during, or fifteen minutes subsequent to ligation. Only one dog (5 per cent) developed ventricular fibrillation, amenable to defibrillation with the application of a single electrical countershock. Also noteworthy was the observation that helium-treated animals experienced few premature ventricular contractions.

Biogalvanic Cells for Cardiac Pacers S-111

Victor P. Satinsky, M.D., John Cassel, B.S., and Alvin Salkind, D.Ch.E., Hahnemann Medical College and Hospital, Philadelphia

The exhibit displays implantable platinum black magnesium cells which utilize body oxygen as a component source for electrical energy to motor a pacemaker. Charts of cell output (1.00-1.20 volts at up to 200 ma) and life expectancy (10 years) will be available. The exhibit includes pictures, slides, and ECG's of experimental animals carrying implants including those of several dogs living with pacemakers motorized by biogalvanic cells. A study of tissue reaction to implanted biogalvanic cells (demonstrating the cells compatibility with a living animal) will be displayed. There will also be a demonstration of the operation of a cardiac pacemaker motorized by a biogalvanic cell placed in Ringer's solution.

Current Advances in Diagnosis and Treatment of Stroke S-112

Robert A. Kuhn, M.D., St. Clare's Hospital, Denville

The great need today is for an incisive, programed attack on interrelated problems of cerebral circulation conducted in the framework of a number of allied medical disciplines. If such a program could be put into effect, there are reasons to believe that biochemical and neurosurgical advances in cerebrovascular disease during the next decade would prove life-saving to a large segment of our aging population. And, if by these means, we manage to check the almost universal ravages of diseased brain circulation, we may also do much for civilization as we know it.

Preventive Treatment of Tuberculosis S-113

Charles R. Ream, M.D., TB-Respiratory Disease Association of New Jersey, Union

This exhibit explains why chemoprophylaxis should be considered and gives information on priority candidates for chemoprophylaxis, who can, and how to institute a preventive therapy program.

Brain Lesions: Early Diagnosis by Cytologic Examination of Cerebrospinal Fluid—Clinical and Histologic Correlation of Findings S-114

Paul T. Wertlake, M.D., Stanley Stellar, M.D., and Brenda A. Markovits, C. T., Saint Barnabas Medical Center, Livingston

Material presented in the exhibit is taken from a one-year 155 case study. From this, it is concluded that cytologic examination of cerebrospinal and ventricular fluid is feasible as a routine technic and diagnostic tool. Such examination should be done routinely in patients suspected of having neoplastic neurologic disease.

Color photographic material is displayed illustrating cellular findings in cerebrospinal and ventricular fluids. Normal cells are shown, as well as abnormal cells seen in cerebrovascular accident, subdural hematoma, multiple sclerosis, Parkinson's disease, and other non-neoplastic neurologic disorders. Neoplastic cells seen in astrocytoma, medulloblastoma, hemangioblastoma, cholesteatoma, meningioma, and other lesions are also illustrated.

Early Diagnosis of Breast Cancer S-115

Edward H. Weiser, M.D., New Jersey Academy of Family Physicians and American Cancer Society, New Jersey Division, Inc., Newark

This exhibit shows the importance of early diagnosis of breast cancer, giving statistics and incorporating a continuous slide program. It depicts the physician's role in teaching breast self-examination as an ongoing health habit, starting in the teens, and describes a joint program of the NJAFP and the American Cancer Society which is being given in high schools throughout the state.

Effect of a Regional Newborn Center on Neonatal Mortality of Referring Hospitals S-116

William C. Ellis, M.D., Vaman T. Chaubal, M.D., Suregesh Shah, M.D., Jagdish Bharara, M.D., and Ronald D. Snyder, M.D., Monmouth Medical Center, Long Branch; and Hahnemann Medical College, Philadelphia

To date, there are no data to show that regionalization of newborn care does lower mortality in the "high-risk" newborn. The region consists of Monmouth and Ocean Counties with 10,000 newborns annually. The seven hospitals in the region have

been retrospectively divided into users and non-users based on the percentage of total live born infants transferred to the regional Newborn Center.

Mortality rates for users and non-users have been determined for a five year control period and for a three year study period. Transport service has been provided by the Regional Center for two years. There is no significant difference in mortality between users and non-users for the control period in total Neonatal, Low Birth Weight, or Group I.

There is a highly significant difference (p is less than 0.0005) between users and non-users for the study period, and the users' study period vs. the control period. There is no significant difference between non-users' control period vs. study period.

This study shows that regionalization is not only possible and practical, but also highly effective.

Pharmacologically Enhanced Visualization of the Portal Venous System Utilizing Phentolamine and Isoproterenol in Combination S-117

Ferdinand J. Carillo, M.D., Francis F. Ruzicka, Jr., M.D., Cyrus Cioffi, M.D., Ronald Van Heertum, M.D., and James Chang, M.D., St. Vincent's Hospital and Medical Center, New York

Arterial portography provides a physiologic means of studying radiographically both the arterial and venous systems of certain abdominal viscera. However, venous visualization is frequently unsatisfactory. Angiography in patients with cirrhosis and portal venous hypertension was studied using control and post-drug arteriography, illustrated in this exhibit. The mechanism of action of these drugs is also illustrated in terms of physiologic pressure measurements and flow meter studies.

Clinical Concepts of Diuretic Therapy S-118

Arthur Bernstein, M.D., Newark Beth Israel Medical Center, Newark

Diuretics are important in many areas of therapy. Their uses are associated with the clinical findings and complications that are described in this exhibit. The mechanisms of diuresis are graphically illustrated as are mechanisms by which sodium and potassium loss are produced. Methods of treating complications of diuretic therapy are described.

Gastrointestinal Cytology in the Community Hospital S-119

William V. Harrer, M.D., Francis X. Keeley, M.D., Francis Barse, M.D., Barry R. Aikey, M.D., and Olympia Draper, C.T., Our Lady of Lourdes Hospital, Camden

This display demonstrates collection methods, diagnostic accuracy, and histopathologic correlations between cytology, gastroscopy, and surgery. Gastric cytology is a valuable adjunct to gastroscopy and radiology in preoperative diagnosis of gastrointestinal pathology.

Academy of Medicine of New Jersey S-120

Sherman Garrison, M.D., President, Bloomfield

The exhibit will outline the educational programs of the Academy in the past year, and plans to include a medical history display as part of the exhibit are being considered.

Immunopathology in Internal Medicine S-121

James A. Hogan, M.D. and Donald R. Tourville, Ph.D., Saint Barnabas Medical Center, Livingston

Purpose of the exhibit is to show the role of immunopathology in making a specific diagnosis. The display shows that immunologic methods are the only way to make a diagnosis in some instances. The exhibit also shows the ease with which immunologic methods can be applied and some of the specific diagnoses that can be made.

Cancer and Other Biomedical Programs at the Institute for Medical Research S-122

Lewis L. Corieli, M.D., Director, Camden

Photographs and slides depict research activity and results at the Institute. The purpose is to apprise Society members of the work of this unique New Jersey institution.

Hoarseness S-123

Myron J. Shapiro M.D., Newark Eye and Ear Infirmary, Unit of United Hospitals Medical Center, Newark

Differential diagnosis, etiology, course, and treatment of various forms of hoarseness, as well as methods of examination—old and new—will be demonstrated in this exhibit.

Carcinoma of the Paranasal Sinuses S-124

Myron J. Shapiro, M.D. and Mark Levey, M.D., Irvington

Here displayed is a three panel exhibit of the various tumors of the nose and sinuses — their diagnosis and treatment.

Aorta-Coronary Vein Grafts S-125

Peter P. Poulos, M.D., N. A. Antonius, M.D., John Coniaris, M.D., Anthony D. Crecca, M.D., Joseph V. Crecca, M.D., Michael A. Chiechi, M.D., Joseph Tafaro, M.D., Anthony Renzuli, M.D., Elizabeth A. Johnson, M.D., Russell W. Brancato, M.D., and Adolf G. Senft, MD., St. Michael's Medical Center, Newark

The exhibit will detail our experience with 160 saphenous vein bypass grafts in 100 consecutive patients. A motion picture of the operation will be shown. Diagnostic procedures, indications, and results will be illustrated. The mortality rate has been two per cent.

Total Hip Replacement—Postero-Lateral Approach S-126

George W. Keyes, M.D. and Kenneth A. Morrissey, M.D. Holy Name Hospital, Teaneck

Pictorially and radiographically, the exhibit will show who is amenable to this procedure and when, why, and how it is done at Holy Name Hospital. Shown by motion picture are the results of the surgery.

The Use of Amniocentesis in the Community Hospital S-127

James P. Thompson, M.D. and Harold M. Bates, Ph.D. Saint Joseph's Hospital, Paterson

The exhibit concerns the feasibility of ante partum monitoring of the at-risk pregnant patient, with special reference to amniotic fluid phospholipid determinations.

1972 Annual Meeting

TECHNICAL EXHIBITS

Saturday, May 6 — 12 noon to 5 p.m.
Sunday and Monday, May 7 and 8 — 9 a.m. to 5 p.m.

In Appreciation

The Medical Society of New Jersey is pleased to recognize, through their generous contributions, the following official patrons of the educational programs presented through the scientific sessions:

Eaton Laboratories
Knoll Pharmaceutical
Geigy Pharmaceutical
A. H. Robins Company
The Upjohn Company
Johnson & Johnson
Schering Corporation

American Association of Medical Assistance State of New Jersey — Message Center

Informational brochures describing the aims and purposes of AAMA, its educational opportunities, and its certification program will be available for distribution. Messages for doctors in attendance at the meeting will be relayed through this booth.

Astra Pharmaceutical Products, Inc. #8

Available will be useful information and descriptive literature pertaining to Xylocaine® (lidocaine), Citanest® (prilocaine), Jectofer® (iron sorbitex), and local and topical anesthetics and intravenous use of Xylocaine® in cardiac arrhythmias.

Biochemical Procedures (Affiliate of Mead Johnson and Company) #22

Available will be information on the latest equipment used in drug test screening by the professional personnel of Biochemical Procedures.

E. & W. Blanksteen Agency, Inc. #11 & #12

E. & W. Blanksteen Agency, Inc., are official brokers for The Medical Society of New Jersey for Accident and Health, Major Expense, High Limit Accident, Term Life Insurance, Hospital-Money, HR-10 Keogh Retirement Plan, and Corporate Master Retirement Plan.

All these programs provide exceptional value for the members because of the group purchasing power of the State Society.

Joseph A. Britton Agency #16

This is the agency which provides officially endorsed professional liability insurance (all forms).

The Carrier Clinic #39

Here described will be the facilities offered at the Carrier Clinic, a private psychiatric hospital.

Data Business Systems, Inc. #13

Data Business Systems, Inc., is the distributor for Control-O-Fax Professional Systems. New procedures to promote office payments and reduce mailing statements are the results of the One Write System used. Also, we distribute Nashua Thermal Paper and "Q" Ledgers and Statements.

Encyclopaedia Britannica, Inc. #17

The new edition of the Encyclopaedia Britannica, the Great Books of the Western World, the Britannica Junior, and other related materials will be on display for the information of those visiting the booth.

Group Health Insurance, Inc. #24

Representatives will be available to answer your questions and distribute literature offered by Group Health Insurance, Inc.

Gyn Cytology and Pathology Associates #43

This laboratory limits its services to the examination of cytology and biopsy specimens. We provide the physician with all the necessary cytology and biopsy supplies including postage-paid mailing containers, with typed descriptive reports returned to the physician the day they are received. Co-directors of the laboratory are Allan Lazar, M.D., certified in anatomical pathology and Karl G. Klinges, M.D., certified in obstetrics/gynecology and cytopathology.

Hoechst Pharmaceutical Company #35

Representatives will be glad to discuss any of Hoechst's products. Featured are Lasix® (furosemide), Surfak®, and Doxidan®.

Lakeside Laboratories, Inc. #28

Lakeside Laboratories' exhibit will include Cantil®, Imferon®, Ircon-FA®, Mercuhydrin®, Methahydrin®, Metatensin®, Norpramin®, the Iron Learning System, and the Learning System on Depression.

David and Charles Levinson Medical Specialists #23

Medco Products—Introducing the Medco Dublett. Dual ultrasound is presented with palm fitted transducers. Trigger points and symptom areas are treated simultaneously.

The Medco-Sonlator Twin—Here is a diagnostic and therapeutic instrument, combining synchronized and pulsed ultrasound with Medcolator current in continuous, pulse and surge settings.

The Medcotherm—A combination of neuro-muscular stimulation and moist heat thermostatically controlled and blended with reciprocating and surging settings.

The Medcolator, models K & G—Displayed here is Medcolator current with straight or interrupted galvanic currents.

Martin Short Wave therapy provides automatic tuning and deep penetration.

Eli Lilly and Company #31

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance will welcome your questions about our pharmaceutical products. You may be particularly interested in discussing Kelex®—cephalexin monohydrate.

Marion Laboratories, Inc. #32

Come see Gaviscon, a unique new specific for treatment of heartburn associated with hiatal hernia, gastroesophageal reflux, and esophagitis. Gaviscon provides pinpoint neutralization of acid in the cardia and fundus . . . a highly viscous gel-like layer of antacid foam floats on stomach contents to inhibit gastroesophageal reflux.

Medical-Surgical Plan of New Jersey #19

Plan representatives will be on hand to answer your questions about Prevailing Fee and the use of Short Form Service Reports, and to explain in detail the services covered under Rider J and also its limitations in diagnostic services. Discussions of these and any other Plan matters will be cordially welcomed.

New Jersey Bell Telephone Company #41 & #42

Telephone services and equipment available for the medical field will be illustrated and explained at the booth.

Ormont Drug and Chemical Company, Inc. #29

New Stabilized Tuberculin PPD Solution markedly decreases false negatives. There is virtually no adsorption loss on glass or plastic of vial or syringe. Full potency is provided for one year and there is no waste.

Sterneedle "stamp test" for rapid, painless, economical (3¢ per test) tuberculin testing, smallpox vaccination, and allergy screening is displayed.

Oxy-Pak is shown. This is a light, refillable emergency oxygen unit with gauge.

Ortho Pharmaceutical Corporation #15

A complete line of medically accepted products for the control of conception and the treatment of vaginitis will be available for inspection by the profession.

Parke, Davis and Company #36

Our representatives will discuss selected pharmaceutical products at the Parke-Davis booth.

PRO Services, Inc. #49

Representatives will have information on the MSNJ approved Professional Association and Keogh Retirement Plan, which is administered by PRO Services, Inc. Also, information on the proposed expanded Keogh legislation will be available.

Prudential Insurance Company of America Coffee Lounge

Prudential is the contractor with the Federal Government for Medicare Part B in New Jersey, North Carolina, and Georgia and for Part A in New Jersey; also with the State of New Jersey for Medicaid.

A. H. Robins Company #26

You are cordially invited to visit the A. H. Robins exhibit and meet our representatives who will welcome the opportunity to discuss products of interest with you.

Roche Clinical Laboratories (Division of Hoffmann-LaRoche) #25

Roche Clinical Laboratories offers a unique opportunity to evaluate this new laboratory service for yourself. Discover the accuracy and reliability provided by automated testing procedures and computerized quality control and data processing.

Roche Clinical Laboratories can satisfy the specific laboratory test needs of physicians, hospital laboratories, and industrial medicine. Stop by to see what this comprehensive service can offer you.

John J. Ryan and Company, Inc. #40

John J. Ryan & Co. has been dealing in municipal bonds since 1946. We have almost twenty-six years' experience with clientele that is national in scope and with individual investors. John J. Ryan & Co. is the municipal bond house that was built with care —care for its customers and care for its reputation. It is the municipal bond house that professionals trust.

Sandoz Pharmaceuticals #18

Sandoz Pharmaceuticals cordially invites you to visit its display where will be featured Mellaril®, Hydergine®, Serentil®, Cafegot P-B®, Fiorinal®, and Bellergal®.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company #14

W. B. Saunders Company, Philadelphia, medical and scientific publisher, has on display a complete line of its medical reference books, monographs, and periodicals. Each is written by authorities especially qualified in their respective fields. Included in the display are many new 1972 publications—for example, Conn: **Current Therapy 1972**; Gray and Skandalakis: **Embryology for Surgeons.** Each book is worthy of your careful consideration.

Schering Laboratories #30

Schering Laboratories invite you to visit their booth where representatives will be available to discuss with you any questions you may have concerning Garamycin® Injectable, Etrafon®, Valisone®, Drixoral®, Afrin®, Celestone®, Soluspan® Injection, or any other Schering product.

Also, books for Practice and Teaching Aids will be available on request by completing the Information Request Form.

G. D. Searle and Company #7

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be information on Ovulen®, Demulen®, Enovid®, Aldactazide®, Flagyl®, Lomotil®, Pro-Banthine®, and other drugs of interest.

South Jersey Surgical Supply Company #44

South Jersey Surgical Supply Company will introduce for the first time the all new "Vitalograph," the electric, fully automatic, vital capacity spirometer for accurate, fast reading of your patients' ventilatory capacities.

We will also show, for the first time in the United States, the brand new modular wall furniture for consultation room, nurses' station, or waiting room.

The all new "Valtronic System 4" comes in a wide choice of tame and wild colors.

E. R. Squibb and Sons, Inc. #10

E. R. Squibb and Sons, Inc. are pleased to present a film review of up-to-date and factual reports on current topics of medical interest and research. They include such subjects as "Drug Abuse," "Aerospace Medicine," "Heart Transplantation," and "Congestive Heart Failure." This series of short films may be seen in our booth at anytime during the convention hours.

Stuart Pharmaceuticals Division of ICI America, Inc. #1

A Cordial invitation is extended to all members and guests to visit the Stuart Pharmaceuticals booth. Trained representatives will be in attendance to answer your questions on our products: Mylanta®, Chewable Sorbitrate®, Sorbitrate® Sublingual and Oral, Kinesed®, Stuartnatal™ 1 + 1, and others.

Winthrop Laboratories #38

Winthrop Laboratories cordially invites you to visit its booth where the following products will be featured: Talwin®, oral brand of pentazocine (as hydrochloride); Isuprel® brand of isoproterenol HCl; USP Mistometer.

Exhibit Hall Hours

Saturday—noon to 5 p.m.

Sunday and Monday—9 a.m. to 5 p.m.

45th ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Saturday through Tuesday
May 6-9, 1972

Chalfonte-Haddon Hall
Atlantic City

Schedule of Events

Saturday, May 6, 1972

10:00 a.m. to 4:30 p.m.—Sale of dinner-dance tickets
MSNJ Registration Desk
(Exhibit Hall, Lobby Floor, Haddon Hall)

12:00 noon to 4:30 p.m.—Registration
(Lobby Floor, Haddon Hall)

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Lobby Floor, Haddon Hall)

*12:00 noon—Golden Merit Award Ceremony
(Rutland Room, First Floor, Haddon Hall)

*2:00 p.m.—Auxiliary President's Report to MSNJ House of Delegates
(Windsor Room, Lobby Floor, Haddon Hall)

*7:30 p.m.—Reception-Buffet Dinner
A special invitation is extended to Auxiliary members (tickets may be purchased at MSNJ Registration Desk —$10.00 per person)
(Vernon Room, Lounge Floor, Haddon Hall)

Sunday, May 7, 1972

9:30 a.m. to 4:30 p.m.—Registration
(Lobby Floor, Haddon Hall)
Tickets for Tea and Fashion Show

10 a.m. to 4:30 p.m.—Sale of dinner-dance tickets
MSNJ Registration Desk
(Exhibit Hall, Lobby Floor, Haddon Hall)

10:00 a.m.—Art Exhibit
County Press and Publicity Books Exhibit
County Activities Pictorial Display
(Lobby Floor, Haddon Hall)

10:00 a.m.—Pre-convention Board Meeting
(Navajo Room, 15th Floor, Haddon Hall)

12:00 noon—Fellowettes' Luncheon
(Blue Room, Office Floor, Chalfonte)

2:30 p.m.—Tea and Fashion Show
(Vernon Room, Lounge Floor, Haddon Hall)
All doctors' wives and guests cordially invited

*6:30 p.m.—Reception honoring President-elect D'Elia
Auxiliary members are cordially invited to attend (Admission by badge)
(Pennsylvania Room, Lounge Floor, Haddon Hall)

Monday, May 8, 1972

8:15 a.m. to 4:30 p.m.—Registration
(Lobby Floor, Haddon Hall)

8:15 a.m. to 9:00 a.m.—Continental Breakfast—complimentary:
(Hallway, 13th Floor, Haddon Hall)

9:00 a.m. to 12:30 p.m.—General Session
(West Room, 13th Floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Sale of dinner dance tickets
MSNJ Registration Desk
(Exhibit Hall, Lobby Floor, Haddon Hall)

1:00 p.m.—Annual President's Luncheon
(Pennsylvania Room III, Lounge Floor, Haddon Hall)
All doctors' wives cordially invited

*8:00 p.m.—Dinner-Dance
(Pennsylvania Room, Lounge Floor, Haddon Hall)

Tuesday, May 9, 1972

8:30 a.m.—Breakfast for County Presidents
(Mandarin Room, 13th Floor, Haddon Hall)

9:00 a.m. to 12:00 noon—Registration
(Lobby Floor, Haddon Hall)

11:30 a.m.—Post-convention Board Meeting
(West Room, 13th Floor, Haddon Hall)

Convention Committee

Chairman—Mrs. Louis Abbamonte
Co-Chairman—Mrs. James Brennan

*MSNJ events to which Auxiliary members are cordially invited.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

206th ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY
May 6-9, 1972

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please Reserve the Following Accommodations—This Reservation Will Be Acknowledged
If room is not available at rate requested, please check here
authorizing us to make reservation at next available rate. ☐

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	Side Ocean View ☐ 25 ☐ 27	☐ 27 ☐ 29 ☐ 31	☐ 22	☐ 25 ☐ 27
	Ocean Front ☐ 36	☐ 36 ☐ 38	☐ 25 ☐ 26	☐ 28 ☐ 29 ☐ 32
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MODIFIED AMERICAN PLAN (BREAKFAST & DINNER) ADD $9.00 PER DAY, PER PERSON ☐

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Name .....

Address .....
PLEASE PRINT

Plus 5% City Tax

NOTE: As check-out hour is 2:00 p.m., rooms may not be ready earlier.

COMMITTEE ON ANNUAL MEETING

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MRS. MARION R. WALTON,
Convention Manager, Trenton

SUBCOMMITTEE ON SCIENTIFIC EXHIBITS

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Paterson
CHAIRMEN AND SECRETARIES
of Scientific Sections



CALORIES / 1 Cup Prepared Soup*

Beef Broth	25	Vegetable	77
Consomme	33	Tomato	79
Chicken with Rice	49	Cream of Asparagus	80
Chicken Gumbo	55	Cream of Chicken	87
Chicken Noodle	62	Beef	99
Chicken Vegetable	68	Cream of Potato	105
Turkey Noodle	72	Cream of Mushroom	131
Vegetable Beef	75	Green Pea	131

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 536, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ..for every meal and, it's made by Campbell

the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences in their activity levels and estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

References: **1.** Editorial: Oral Contraceptives: Which Pill for Which Patient? Patient Care *3*:90-115 (Feb.) 1969 and *4*:135-145 (June 15) 1970. **2.** Greenblatt, R. B.: Progestational Agents in Clinical Practice. Med. Sci. *18*:37-49 (May) 1967. **3.** Kistner, R. W.: Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W.: The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H.: Clinical Evaluation of Side Effects of Current Oral Contraceptives, J. Reprod. Med. *6*:50-55 (Feb.) 1971. **6.** Orr, G. W.: Oral Progestational Agents: Therapy and Complications, S. Dakota J. Med. *22*:11-17 (Jan.) 1969

the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slight progestogen dominance. It has an excellent record of patient acceptance.

Ovulen®

Each white tablet contains: ethynodiol diacetate 1 mg / mestranol 0.1 mg

SEARLE

For brief summary of prescribing information, see following page.



the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

Enovid-E®

Each tablet contains: norethynodrel 2.5 mg., mestranol 0.1 mg.

Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.

for the 3 phases of Eve:

a family of O.C. products

Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 196 **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study. Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

SEARLE Products of SEARLE & CO.
San Juan, Puerto Rico 00936

Enovid-E®

norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

SEARLE **Enovid-E®**

brand of norethynodrel with mestranol

Product of G. D. Searle & Co.
P.O. Box 5110, Chicago, Illinois 60680
Where "The Pill" Began

Pollution can be taxing



Some people oppose pollution-stopping measures because they may increase taxes.

The problems of pollution can only be conquered when we, as citizens, recognize that it costs money to fight pollution.

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penicillin VK	**Uticillin® VK**
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fluorometholone	**Oxylone®**
reserpine	**Reserpoid®**

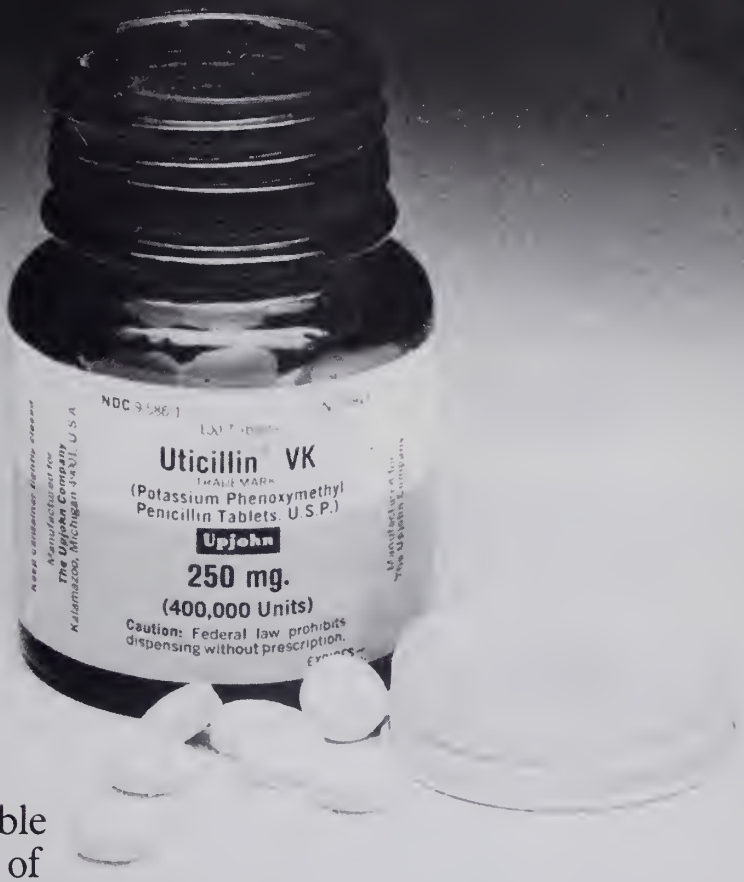
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Upjohn has been able to reduce the price of potassium phenoxymethyl penicillin without reducing the quality you expect from an Upjohn product.

Uticillin® VK

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Available in 250 and 500 mg tablets; 250 mg/5 ml and 125 mg/5 ml flavored granules for oral suspension.

Keeping quality up



and cost down



SUSTAINED RELEASE VITAMIN C

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THE 500 mg. CAPSULE

CEVI-BID releases Vitamin C through its unique micro-dialysis process at a continuous, smooth, predictable rate for a 24 hour period on b.i.d. dosage—dependent only on the presence of fluid in the g. i. tract, and independent of pH or other variables.

CEVI-BID avoids the "peak and valley" blood levels usually obtained from t.i.d. dosage of Vitamin C tablets.

Prescribe CEVI-BID, the 500 mg. sustained-release Vitamin C capsule whenever Vitamin C is indicated.

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Special Article

Here is an innovative approach that could make a community hospital a real teaching agency.

An Innovation in Continuing Medical Education

The Senior Medical Consultants Program
Grant Loavenbruck, M.S.W., Research Director
Joseph Moldaver, M.D., Director, New York

Continuing medical education, the springboard for quality medical care today, is sorely in need of innovative change. Traditionally the medical schools have been the foci for the intern's, resident's, and attending physician's continuing medical education. The health care structure has become so complex (and the other demands made upon the medical schools have become so burdensome), however, that an increasingly larger role in continuing medical education must befall the community hospital. Is your community hospital equipped to meet this challenge?

The Senior Medical Consultants Program, sponsored by National Institutes of Health (NIH), Bureau of Health Manpower Education, is attempting to disseminate teaching expertise from university medical centers to non-affiliated community hospitals, add a previously underutilized medical manpower resource to the medical education milieu, and generate noteworthy, relevant continuing medical education when and where the practicing physician will use it. Compulsorily retired and near-retired faculty members from medical schools in New York, New Jersey, and Connecticut were selected according to rigorous criteria as the underutilized manpower resource for this pilot project. Their faculty status, eminent reputations, and desire to continue teaching, especially where most needed, were the characteristics which made them the most logical manpower choice for this program. These physician-teachers are acting as consultants to selected community hospitals, engaging in patient presentations and informal discussions with house staff members and attendings several times over the course of an academic year. They are serving as educational adjuncts to existing continuing medical education programs.

Need for Change

In the area of continuing medical education a marked shortage and maldistribution of quality physician-teachers already exists. This shortage and maldistribution will worsen as responsibility for offering CME courses continues its present trend of shifting from the medical schools to non-affiliated hospitals. In 1962-1963, medical schools offered 55 per cent and hospitals offered 9 per cent of the CME courses; in 1971-1972 medical schools offered 38 per cent of the CME courses and hospitals offered 26 per cent.[1] We see, therefore, that the creation of physician-teacher manpower resources to staff these non-affiliated hospital CME programs satisfies a growing critical need. Many of these non-affiliated hospital CME programs currently count on the teaching services of their own attending staff. Senior Medical Consultants Program is designed to supplement these existing medical education programs.

The American Association of Medical Colleges Committee on the Expansion of Medical Education called for "diminished dependence upon the importation of foreign trained M.D.'s[2]." Until then, however, our non-affiliated hospitals have the yet unattained goal of better education of these foreign physicians, both for the good of the many patients they serve here and for the health of the doctors' own countrymen. Exceptional, high quality physician-teachers are necessary for this difficult task—men who can both impart complex medical knowledge and move beyond cultural barriers. Many of the Senior Medical Consultants have extensive teaching

[1] "Medical Education in the U.S.—1970-71" in JAMA, Nov. 23, 1971, Vol. 218, No. 8
[2] AAMC Committee Report, *Journal of Medical Education*, 46:105-116, 1971

experience with foreign medical graduates. One particularly encouraging sign that the CME programs of these non-affiliated hospitals will be upgraded in the near future is the increase in the proportion of hospital directors of medical education (DME) who are full-time personnel. Sixty-four per cent of all DME's are now full-time.[3] It is with these physicians that the SMC staff and the consultants themselves most often communicate and coordinate their teaching activities.[4]

Today we need to extend medical education into ghettos, rural areas, and suburbs, which do not have medical school professors readily at their disposal, but do have to deliver health care. With the galloping complexity of medical-technologic advances, the question remains, however, how do we entice these practicing physicians to continue their medical education? There are little or no legal or professional requirements for them to meet, once they have passed their state boards.[5] Numerous methods for the non-affiliated hospital are available in this respect, but the method with the most lasting impact would seem to be "the recruitment of qualified physician-teachers."

Innovative programs such as Senior Medical Consultants might be a step in the right direction toward negating the need for such a coercive tactic as compulsory education for attending physicians.

Participating Hospitals

This program, which started only four months ago, has been functioning in nineteen hospitals; hospitals in which teaching sessions have already been requested and scheduled and/or held, thus far. There is excellent potential for scheduling sessions in more hospitals at the present time. Some preliminary review of the data on these 19 hospitals indicates the following:

1. They are all medium-sized hospitals (the mean size is 347 beds).

2. They have minimal or no affiliation with a medical school.

3. All but one have at least 80 per cent of their house staff who are foreign medical graduates.

4. Of the nineteen hospitals, eight are in New Jersey, nine are in New York State, and two in Connecticut —located in suburban areas, urban areas, and ghettos.

5. Of the nineteen hospitals, three serve a primarily high income population, three a primarily low income population and thirteen a "mixed" income population.

6. All of the participating hospitals state a need to improve their medical education programs in a wide range of specialties; mostly in internal medicine, rheumatology, pediatrics, surgery, obstetrics, gynecology, pathology, psychiatry, neurology, and radiology.

7. All of these hospitals have directors of medical education, twelve of whom are part-time and seven of whom are full-time.

8. Some of the participating hospitals already have well developed continuing medical education programs with medical school professors consulting, but these hospitals were so impressed with the high quality of the Senior Medical Consultants that they requested inclusion of a particular specialty or sub-specialty in their own programs.

The Physician Teachers

Faculty members are from medical schools in New York, New Jersey, and Connecticut who are approaching or who have reached a predetermined retirement age. Many of these faculty members wish to continue teaching and being near retirement have increasing time and interest to devote to hospital education programs. Their status as faculty members ensures that their teaching and communicating skills have been highly developed.

The project's list of participating physician-teachers is still expanding due to a continuous recruitment program, the basis of which has generally been the attractiveness of the concept itself. The number of physician-teachers so far stands at 44. Multiple specialties are represented in an outstanding list of talent including internal medicine, obstetrics, gynecology, ophthalmology, pathology, pediatrics, psychiatry, radiology, rehabilitation

[3]Medical Education in the U.S., 1970-71, *op, cit.*
[4]See Vaun, W. and Leonard, J., article—"The Director of Medical Education" in *The Medical Staff in the General Hospital*, McGraw-Hill, New York, 1967, and Letourneau, Charles, *The Hospital Medical Staff*, Starling Publ., Chicago, 1964, for detailed descriptions of the roles of DME's.
[5]In recent years, however, a few states have legislated such requirements. Perhaps this represents the foundation of a future national trend.

medicine, surgery, and genetics. The majority of these physician-teachers are committing themselves to between two and four sessions per month. This pool of medical educators is confined to those who have the title of professor, associate, or assistant professor, and who have had extensive experience in teaching, diagnostic work, and research. These physician-teachers, in keeping with the medical tradition, believe in the use of clinical conferences with case presentations as the most direct and effective way of enhancing continuing medical education. These physician-teachers are continuously engaged in the process of up-dating their own and their students' medical knowledge, thus making them doctors of the future not of the past.

Evaluation and Follow-up

Both the hospital and the physician-teacher are asked to complete a short evaluation to record salient facts and reactions to each teaching session. Upon receipt of the evaluation, a check for the honorarium is issued to the physician-teacher.

Description of Consultation Services

Physician-teachers are contributing to the programs by being available for meetings several times a month, rather than by presenting only a single lecture at a hospital. In this way, working relationships are developing between them and the hospital staff members. There is more potential, consequently, of involving those attendings and local physicians who do not usually participate in continuing education programs. Some physician-teachers are able to participate in clinical conferences only a few times a year; more commonly the pattern is for them to offer their services much more often, perhaps up to two or three times a week. Those with sufficient time are rotating among several hospitals, visiting each one weekly. The program is flexible to accommodate the needs of both hospital programs and physician-teacher's schedules. The program provides a token honorarium for each session (about two to three hours). The teaching activity is considered by the physician-teachers as a civic service. These teachers are not to supplant private consultants. They are not involved in any peer function. The program is flexible enough to conform to the needs and desires of the utilizing hospital and these men could participate as desired or requested in the diagnosis or management of complex cases, in the introduction of new approaches and methods, and aid in the creation of small "teaching centers." They participate in clinical conferences and ward rounds and, in general, bring teaching center expertise to outlying institutions. The outstanding feature of this innovative teaching program is that it delivers the expertise of medical schools directly to the practicing physician in relation to the patients who are most relevant to him—his own.

Evaluation

The evaluation of this program will fall into one of the following categories: (1) *hospitals'* CME needs, (2) *physician-teacher manpower* resources for meeting these needs, (3) *utilization,* and (4) *impact* of program. Data relevant to the program will be acquired from the reactions of directors of medical education, chiefs of services, hospital residents, interns, and attendings to those hospitals, and from the physician-teachers. The staff of senior medical consultants is beginning to gather pertinent data through a variety of evaluation mechanisms, data of both quantitative and qualitative natures.

Conclusion

While university hospital and medical school complexes are the main teaching centers, the activities of physician-teachers in this program will contribute to the development of small teaching centers in community hospitals which do not have this type of activity. The dissemination of teaching resources may, in time, help hospitals to attract house staff members with a wider variety of backgrounds than is now the case. In sum, a continued healthy competition between non-affiliated hospitals and those affiliated with medical schools may very well enhance the educational and health service systems.

Perhaps the real contributions of such an innovation as Senior Medical Consultants can be summarized best in some of the words of participating hospitals and physicians.

One teacher commented: "The attendance was a most satisfactory one, and I enjoyed being with the group very much, because they evinced an interest which exceeded my most sanguine expectations. Following the formal talk, I invited an open discussion and question period. This also exceeded my expectations, particularly since most of it emanated from the resident staff." The Senior Medical Consultants' staff was curious to learn of the hospital's evaluation of the same teaching session. It came a few days later in the form of an invitation to the same teacher to conduct eight additional teaching sessions in his field, plus a separate invitation for eight teaching sessions to be conducted by teachers from another specialty field. Another hospital evaluating the same physician-teacher wrote: "Your adjectives should have included 'excellent'. Dr. . . . captivated everyone. Age has done nothing to his volume of knowledge or familiarity with modern medicine. He was just a joy."

An Advisory Council for the Senior Medical Consultants Program has been formed, consisting of leading clinicians, educators, administrators and leaders in the health fields (their names are listed below*). Council members have been meeting regularly over the past ten months to formulate program policies.[6]

*Advisory Council, Senior Medical Consultants (S.M.C).

Dana W. Atchley, M.D.
Jeremiah A. Barondess, M.D.
David P. Barr, M.D.
Addison Bennett
Detlev W. Bronk, Ph.D.
Andre Cournand, M.D.
A. Wilbur Duryee, M.D.
Richard H. Freyberg, M.D.
Frank Glenn, M.D.
George H. Humphreys II, M.D.
W. Graham Knox, M.D.
John T. Kolody
Joseph Moldaver, M.D.
Robert L. Patterson, M.D.
Howard A. Rusk, M.D.
Frank E. Stinchfield, M.D.
L. Ramsay Straub, M.D.
Peter B. Terenzio
Irvin G. Wilmot
Irving S. Wright, M.D.
Harry M. Zimmerman, M.D.

[6]Inquiries from directors of medical education, hospital administrators and interested faculty members are welcome, and should be addressed to Joseph Moldaver, M.D., Director, Senior Medical Consultants Program, 140 East 54th Street, New York, 10022 (phone: 212-838-6047); or the Administrative Office of Senior Medical Consultants Program, St. Barnabas Hospital, Third Avenue and 183rd Street, Bronx, New York 10457 (phone: 212-295-2000).

Influenza in 1971

The federal government reported, at the end of 1971, that outbreaks of influenza were hopscotching across the country in a fashion typical of the 1969 epidemic that struck an estimated 30 million Americans.

The National Center of Disease Control (NCDC) said some of the influenza has been identified as the Hong Kong variety and some as "influenza-like." School absenteeism, ranging as high as 30 per cent, was reported by communities hardest hit by the infection.

The influenza struck swiftly and spread rapidly. Practically no outbreaks were reported by state health departments in a telephone survey conducted by the NCDC on November 17. But another phone survey on December 21 revealed outbreaks in New England, the middle Atlantic states, midwest, south, and the far west. The Hong Kong influenza "has been documented in Connecticut, Kansas, Michigan, New Jersey, and Utah."

The World Health Organization said that influenza epidemics, many of them caused by the Hong Kong virus, have broken out in both eastern and western Europe.

140/90 is normal blood pressure...or is it?

An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

Study Findings. Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"[1]—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

Other Studies. Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

Another Point of View. Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."



Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

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HydroDIURIL®
(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Kannel, William B., *et al.*, "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Consultant, Jan. 1971.

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HydroDIURIL®

(Hydrochlorothiazide|MSD)

Therapy to Start With

Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

PRECAUTIONS: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided o treated by use of potassium chloride or giving food with a high potassium content. Similarly, any chlorid deficit may be corrected by use of ammonium chlorid (except in patients with hepatic disease) and largel prevented by a near normal salt intake. Hypochloremi alkalosis occurs infrequently and is rarely severe. I severely edematous patients with congestive failure o renal disease, a low salt syndrome may occur if dietar salt is unduly restricted, especially during hot weathe

Thiazides may increase responsiveness to tubocu rarine. The antihypertensive effect of the drug may b enhanced in the postsympathectomy patient. Arteria responsiveness to norepinephrine is decreased, neces sitating care in surgical patients. Discontinue drug 4 hours before elective surgery. Orthostatic hypotensio may occur and may be potentiated by alcohol, barbit urates, or narcotics.

Pathological changes in the parathyroid glands wit hypercalcemia and hypophosphatemia have been see in a few patients on prolonged thiazide therapy. Th effect of discontinuing thiazide therapy on serum ca cium and phosphorus levels may be helpful in assess ing the need for parathyroid surgery in such patient Parathyroidectomy has elicited subjective clinical im provement in most patients, but has no effect o hypertension. Thiazide therapy may be resumed afte surgery.

Use cautiously in hyperuricemic or gouty patient gout may be precipitated. May affect insulin require ments in diabetics; may induce hyperglycemia an glycosuria in latent diabetics.

ADVERSE REACTIONS: Rare reactions includ thrombocytopenia, leukopenia, agranulocytosis, apla tic anemia, cholestasis, and pericholangiolitic hepatiti Nausea, vomiting, diarrhea, dizziness, vertigo, pare thesias, transient blurred vision, sialadenitis, purpur rash, urticaria, photosensitivity, or other hypersens tivity reactions may occur. Cutaneous vasculitis pr cipitated by thiazide diuretics has been reported i elderly patients on repeated and continuing exposu to several drugs. Scattered reports have linke thiazides to pancreatitis, xanthopsia, neonatal thron bocytopenia, and neonatal jaundice. When adver reactions are moderate or severe, the dosage thiazides should be reduced or therapy withdraw

For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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Indications

Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications

Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings

When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children Not recommended for use in children under 12 years of age.

Precautions

In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions

Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration

The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage

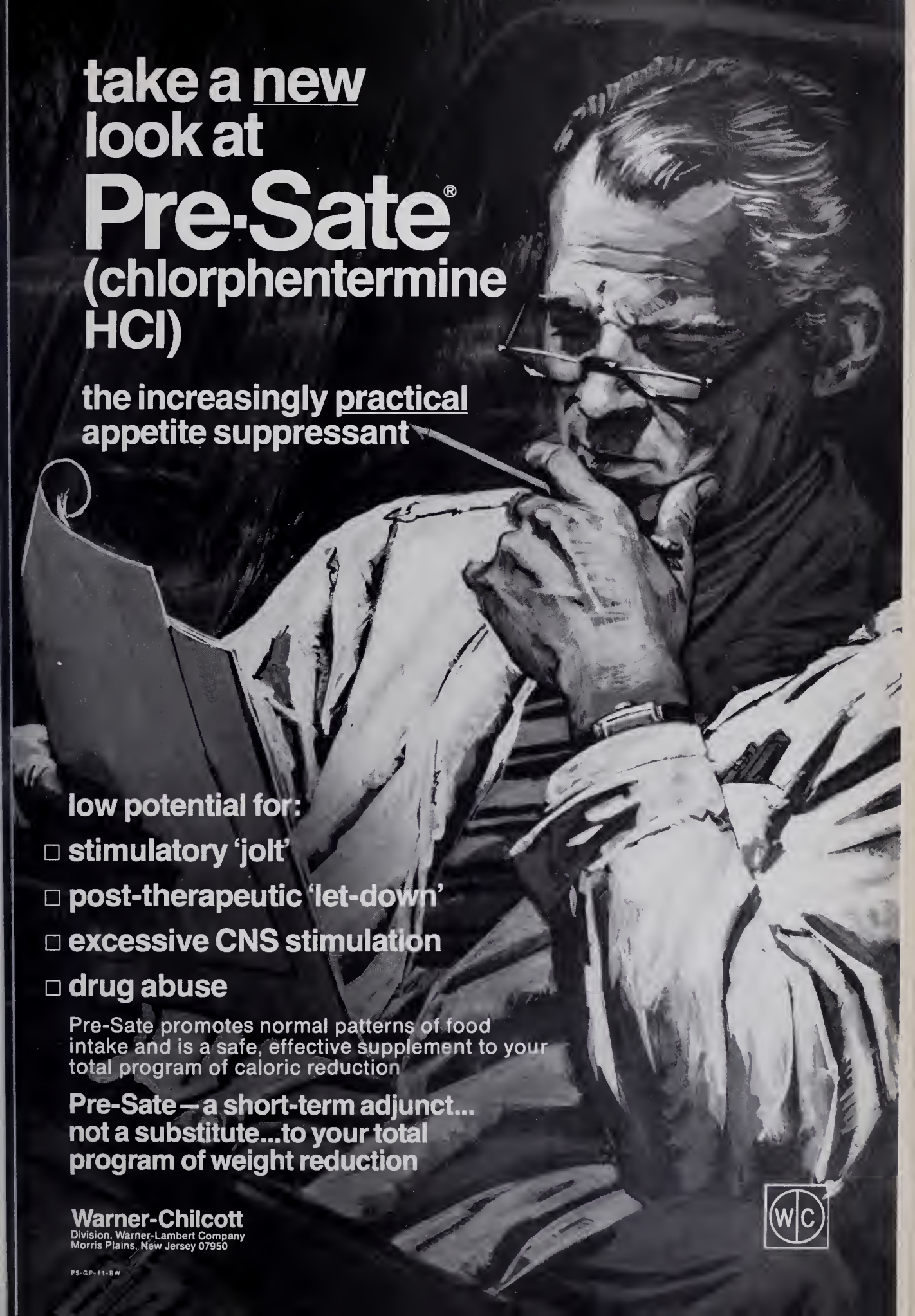
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied

Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo

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A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reparts of 14 investigators. **Diagnosis was confirmed by culturol identitication of *N. gonorrhaeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited abave under "criteria for cure" except when the investigator determined that reinfectian through additianal sexual cantacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included.* JA72 1848-S

...obin, hemotocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal valunteers, a reduction in urine output was noted. Extensive renal functian studies demonstroted no consistent changes indicative af renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dase (5 ml) intramuscularly. Patients with gonorrheal proctitis ond patients being re-treoted after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistonce is known to be prevalent, initial treatment with 4 groms (10 ml) intramuscularly is preferred.

Female—single 4 grom dose (10 ml) intromusculorly.

How supplied: *Vials, 2 ond 4 grams—with ampaule af Bacteriostatic Water for Injection with Benzyl Alcahol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrachloride pentohydrote equivolent to 400 mg spectinamycin per ml. Far intramuscular use only.

Susceptibility Pawder—for testing *in vitro* susceptibility of *N. ganarrhaeae*.

Human pharmacology: Rapidly absorbed after intromuscular injection. A two-grom injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 haurs. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml ot 8 hours.

For odditionol product informotion, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



Overcrowding, unemployment, discrimination and hunger contribute to mental illness. They also serve as barriers between the poor and proper diagnosis and effective treatment of mental illness.

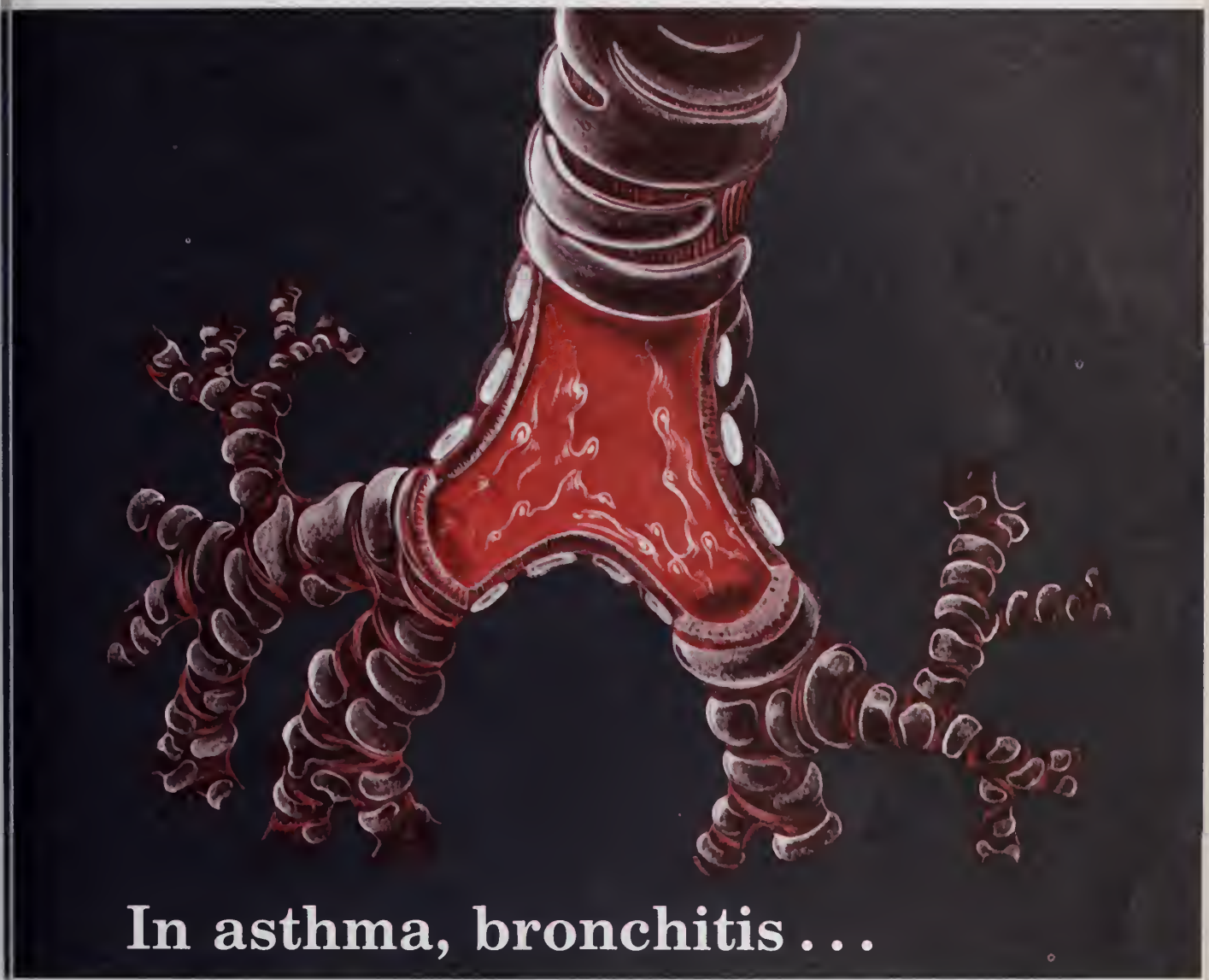
The National Association for Mental Health is committed to tackling the problems of the disadvantaged, by helping them secure the benefits of advances in the prevention, diagnosis and treatment of health problems.

Your Mental Health Association is working to ensure that services for the mentally ill are provided in areas where they are needed the most.

JOIN AND SUPPORT YOUR MENTAL HEALTH ASSOCIATION

Citizens Who DO Make A Difference

MOVE-OUT STICKY MUCUS...



In asthma, bronchitis...

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

"For the viscid sputum, potassium iodide (... preferable as enteric coated tablets) may be best."[2]

Provide tastefree, well-tolerated KI in convenient SLOSOL coated tablets–

IODO-NIACIN®

Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

COLE

please see next page for prescribing information–

Promote Productive Cough-



"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

"... there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. ℈ tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

COLE
PHARMACAL CO. INC.
St. Louis, Mo. 63108

NEW JERSEY DOCTORS' NOTEBOOK

Keeping the Retarded Home

Our Committee on Mental Retardation calls attention to the fact that doctors are often too quick to recommend institutional placement for the mentally retarded. Following is the policy statement by that Committee:

Home Care of the Mentally Retarded Versus Residential Placement

It is the judgment of the Committee on Mental Retardation that very often the primary physician recommends residential placement of a mentally retarded infant or young child. This early recommendation in many instances is detrimental to the infant or child and may also lead to a guilt complex on the part of the parents.

It is recognized that there are some circumstances under which early residential care is timely and essential.

There are valid reasons for home care of the young retarded person, regardless of whether one looks at the problem from the viewpoint of society, the parent, or the child. Society, the taxpayer, is saved enormous sums of money by home care rather than traditional residential care. Furthermore, indiscriminate residential placement places infants and children in beds who do not need extensive rehabilitation or 24 hour nursing care, thus, depriving infants and children who do need this residential placement of access to beds in institutions.

From the parent's viewpoint, home care essentially is preferable, because it permits sufficient time for the parents to make a rational plan for the care of the child. This permits parental decision based on facts and experience rather than on a professional opinion alone. The retarded child benefits from home care by receiving love, sibling contact, and a greater emotional development. It permits the mother-child relationship in stimulating emotional maturation as well as physical care. A second argument for home care is that often initially there is an inaccurate assessment of the degree of mental retardation, which could be catastrophic to the child if early residential placement has occurred.

The early residential placement of a victim of Down's Syndrome is usually not indicated. This deprives the child of emotional maturation, adjustment to society, and the realization of his or her full potential. Most of these children can attend kindergarten and special classes in the regular school systems, thus permitting additional emotional maturation and development, which are lost in a residential setting.

It is thus recommended that residential placement for the mentally retarded infant or child be held off as long as possible, with the final decision being made by the parent with professional guidance.

Committee on Mental Retardation

Miles E. Drake, M.D., Chairman
Eugene Revitch, M.D.
Catherine Spears, M.D.
Robert A. Weinstein, M.D.
Harry Yolken, M.D.

Erratum

In the article on lead poisoning, pages 101 through 105 of the February 1972 issue (Volume 69, No. 2), the measure of the lead serum levels was listed as milligrams. It should, of course, have been micrograms. *The Journal* regrets that this error was not picked up in the author's proofs and publishes this correction to set the record straight.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during February 1972:

	1972 February	1971 February
Aseptic meningitis	9	3
Primary encephalitis	1	0
Hepatitis: Total	308	327
Infectious	222	264
Serum	86	63
Malaria: Total	1	19
Military	1	19
Civilian	0	0
Meningococcal meningitis	8	5
Mumps	82	273
German measles	32	37
Measles	74	50
Salmonella	58	54
Shigella	13	30

Tuberculosis Mortality

Tuberculosis is now 23rd in the United States among the leading causes of death. This should not obscure the more important fact that it is by far the most important leading cause of death among the reportable infectious diseases. During the last decade for which final mortality statistics are available (1959-1968), tuberculosis killed more Americans than all the other reportable infectious diseases combined. Only the pneumonias, which are classified with the non-notifiable acute communicable diseases, accounted for more deaths than tuberculosis.

In recent years the still large number of tuberculosis deaths have been viewed with the same degree of concern as deaths from other communicable diseases, which, singly or as a group, contribute relatively fewer deaths to the general mortality rate.

Because local health agencies have been successful in reducing incidence, prevalence, and mortality rates, an illusion may have been created that tuberculosis is no longer a serious public health problem. In 1970, for example, New Jersey reported 2,013 new cases of tuberculosis; a case rate of 28.0 per 100,000. Furthermore, 1,281 new active cases were reported; a case rate of 17.8 per 100,000. In addition, the cause of death for 245 individuals was tuberculosis that year. In spite of considerable reduction in case rates and death rates, tuberculosis continues to be a tragic personal and social evil as well as a drain on the economy.

New Pacemaker Development

A Columbia University engineer and a team of Israeli researchers have developed an electronic heart pacemaker powered by batteries that can be recharged without removing them from the patient's chest. These nickel-cadmium batteries are expected to last about 25 years. They are recharged by transmitting radio frequency power to them through the patient's skin. Dr. Robert Bernstein, a professor of electrical engineering at Columbia's School of Engineering and Applied Science, indicates that this cardiac pacemaker had distinct advantages over current models, which depend upon mercury cells.

The mercury cell batteries, he said, "run down after 18 to 24 months of use and must be replaced by a surgical operation." Recharging pacemaker batteries without opening up the patient, he said, is an obvious improvement.

The new electronic pacemaker was developed in Israel in 1970 while Dr. Bernstein was a Visiting Fellow at the Weizmann Institute in Israel. His research colleagues are Drs. H. Fischler and E. Frei of Weizmann Institute, and Dr. E. Kaplinski and H. N. Neufeld of the Tel Hashomer Heart Institute.

The American manufacturer of the new cardiac pacemaker was identified as Electro-Catheter Corporation of Rahway, New Jersey. Although its cost is far from being set, Dr. Bernstein said he expects it will be "under $1,000," which is approximately the cost of non-rechargeable pacemakers.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—P. Cuni, M.D., 2620 SW 14th Street, Miami, Florida 33145. University of Havana 1957. Group, partnership, solo, institution. Available.

CARDIOLOGY—Robert F. Marvin, M.D., 1118-C John Street, Charlottesville, Virginia 22903. Temple 1965. Board certified in internal medicine. Group, partnership, or hospital. Available July 1972.

GASTROENTEROLOGY—Arthur Tuch, M.D., 914 South Avenue, Apt. G6, Secane, Pennsylvania 19018. NYU 1965. Board eligible. Partnership or group. Available November 1972.

Kambiz Azmudeh, M.D., 700 Riddle Road, #16, Cincinnati, Ohio 45220. Tehran 1964. Board eligible. Group or partnership. Available July 1972.

GENERAL PRACTICE—Biagio Scialpi, M.D., 156 Caryl Avenue, Yonkers, New York 10705. University of Bari (Italy) 1949. Solo or partnership. Available July 1972.

INTERNAL MEDICINE—Stephen M. Druckman, M.D., 3910 Powelton Avenue, Philadelphia, Pennsylvania 19104. Jefferson 1967. Board eligible. Subspecialty, gastroenterology. Partnership or group. Available July 1972.

T. N. Paul, M.D., 2900 Lincoln Avenue, North Riverside, Illinois 60546. Calcutta Medical 1954. Board eligible. Subspecialty, endocrinology. Group, partnership, or institutional. Available July 1972.

Hugh McGrath, Jr., M.D., 608 Magnolia Street, New Llano, Louisiana 71461. Georgetown 1966. Board eligible. Group. Available July 1972.

Manuel M. Liu, M.D., 655 East 14th Street, New York 10009. University of Philippines 1965. Board eligible. Subspecialty, chest diseases. Institution, group, or partnership. Available August 1972.

NEUROLOGY—Richard N. Selby, M.D., 1705 Spaatz Drive, CAFB, Rantoul, Illinois 61886. Downstate Medical 1962. Board eligible. Group, partnership, institution, or solo. Available September 1972.

OPHTHALMOLOGY—J. Louis Pecora, M.D., 18 Tilton Avenue, Kittery, Maine 03904. Downstate Medical Center 1967. Board eligible. Association or solo. Available July 1972.

Barry F. Bader, M.D., U.S. Quarantine Station, 1365 Bay Street, Staten Island, New York 10305. New York Medical 1967. Board eligible. Group, partnership, or association. Available July 1972.

Kenette Kay Sohmer, M.D., Apt. 209, Knight House, Cooperstown, University of Kentucky, Lexington, Kentucky 40506. University of Kentucky 1968. Board eligible. Group, partnership, or solo. Available July 1972.

Ronald C. Moore, M.D., 13 West Kinney Avenue, Mount Pocono, Pennsylvania 18344. Jefferson 1919. Board eligible. Group or partnership. Available February 1972.

Gilbert B. Sussman, M.D., 16 Hopkins Road, Liverpool, New York 13088. Downstate Medical Center 1967. Group, partnership, or association. Available July 1972.

ORTHOPEDIC SURGERY—Stephen Dineberg, M.D., 4412A, USAF Academy, Colorado Springs, Colorado 80900. Hahnemann 1965. Board eligible. Partnership or solo. Available June 1972.

OTOLARYNGOLOGY—Stefan A. Kucinski, M.D., Newton Professional Center, Newton, Connecticut 06470. Warsaw (Poland) 1959. Board eligible. Solo. Available.

Stephen R. Geller, M.D., 3807 Pecan Street, Portsmouth, Virginia 23703. Chicago 1966. Board eligible. Group or partnership. Available July 1973.

PEDIATRICS—Sanford S. Epstein, M.D., 621 Empire Boulevard, Brooklyn, New York 11213. University of Bologna 1965. Board eligible. Group, partnership, or association. Available July 1972.

Noel M. Wiederhorn, M.D., 42-10 Golden Street, Flushing, New York 11355. New York Medical College 1969. Board eligible. Group or partnership. Available June or July 1972.

SURGERY—John M. Parsons, M.D., 215A 84th Street, Virginia Beach, Virginia 23451. Jefferson 1964. Board certified. Partnership or group. Available July 1972.

C. R. Chatterjee, M.D., Department of Urology, University of North Carolina Medical Center, Chapel Hill, North Carolina 27514. University of Calcutta 1958. Board certified. Subspecialty, urology. Partnership or association. Available July 1972.

N.V. Dandekar, M.D., 10 Autumn Street, #17, Boston, Massachusetts 02215. G. S. Medical (India) 1958. Board certified. Subspecialty, thoracic surgery. Group, partnership, hospital.

Brian G. Miscall, M.D., 4214 Bethel Church Road, Columbia, South Carolina 29206. Cornell 1961. Board certified. Group, fulltime hospital, partnership. Available September 1972.

M. Fallahnejad, M.D., 5115 Wissahickon Avenue, A-26, Philadelphia, Pennsylvania 19144. Tehran 1961. Subspecialty, thoracic surgery. Board certified in both general and thoracic surgery. Group, partnership, or teaching. Available.

UROLOGY—N. R. Amin, M.D., 2250 South 17th Avenue, North Riverside, Illinois 60546. B. J. Medical College (India) 1961. Group or institution. Available.

FDA Proposes Box-Labeling Regulation

The U. S. Food and Drug Administration has proposed one new regulation and finalized another, both of which will have an impact on the physician in his daily practice.

The first regulation, published as a proposal in mid-October and expected to be initiated soon, will require advertisements for prescription drugs that appear in medical journals, the package insert, and all other product labeling to include special information where the FDA has raised doubts as to effectiveness. This so-called "box-labeling" (named because the data will be enclosed in a special box) could be confusing unless the practitioner is thoroughly informed about past events related to the FDA's drug effectiveness review.

In 1962, Congress passed amendments requiring all new medicines to demonstrate "substantial evidence" of effectiveness. The new law also required the FDA to review the effectiveness of hundreds of pre-1962 prescription drugs.

With the cooperation of the industry, FDA turned to the National Academy of Science-National Research Council for assistance. Panels, drawn largely from the universities and teaching hospitals, were named to evaluate medicines in 30 therapeutic categories. The panels examined published information and relied to a considerable extent on their own experience and that of their associates. They reported back to the FDA as to whether they considered drugs to be "effective," "probably effective," "possibly effective" or "ineffective" in relation to more than 10,000 therapeutic claims.

Since the experts had difficulty classifying many products with any degree of scientific finality, many of the findings were imprecise, hedged, or qualified to encompass differences in opinion. Two new categories were created—"effective, but" and "ineffective as a fixed combination"—to categorize products that were, respectively, held to be effective medicines but needing some labeling changes, or medicines that were combined in fixed ratios that panelists believed constituted "irrational" therapy. The latter classification was based on the philosophical contention that drugs, while they may be fully effective, should be individually titrated rather than combined in fixed dosages.

In many cases, pharmaceutical firms accepted the subsequent edict of the FDA that generally, but not always, reflected the recommendation of the NAS-NRC panels. Some products were voluntarily removed from the market. In other cases, the drug firms differed with the government's findings, and they set about developing new proofs of effectiveness or contested the FDA's action in other ways.

Many of the controversies about individual drugs remain unsolved and the affected products remain on the market and available for prescription. Some of them are long-established, widely-used medications. It is this category of medicines to which the box-labeling would apply. The new FDA regulations propose notifying the doctor that there is a difference in viewpoint about a given medication, specifically that the NAS-NRC, or in some cases the FDA acting on its own, regard the product to be something less than effective for certain stated indications based on available evidence.

MESSAGE CENTER
Exhibit Floor
courtesy of
New Jersey State Medical Assistants Association

COFFEE LOUNGE
Exhibit Floor
sponsored by
The Prudential Insurance Company of America

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899



a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® can be compared to codeine in analgesic efficacy, it is not a narcotic. So patients receiving Talwin for prolonged periods face fewer of the consequences you've come to expect with narcotic analgesics. And that, in the long run, can mean a better outlook for your chronic-pain patient.

Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe—day or night—even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1583)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

ANNOUNCEMENTS

Medical Women Meet

The next meeting of the New Jersey Medical Women's Association will be held Wednesday, April 12, 1972, at the Holiday Inn in Kenilworth at 6:00 p.m. Hannah Elizabeth Seitzick-Robbins, M.D., of Trenton will be honored at this meeting as the "Woman of the Year."

OB-GYN Colloquium in May

The American College of Obstetricians and Gynecologists announces an annual clinical meeting in Chicago, May 1 to 4, 1972. The program includes a variety of obstetric and gynecologic topics of current interest—lectures, seminars, reports on research, and breakfast and luncheon conferences. For non-members the registration fee is $75. For further information, please write to Dr. Donald Richardson, American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago 60603.

Educational Programs in Trenton

The Mercer Hospital in Trenton announces two special presentations for May and June 1972. On May 2, the meeting will concern the asthmatic, and the June 6 agenda is listed as "Pitfalls of Testing for Cystic Fibrosis." Meetings are held at 7:30 p.m. on the 5th floor conference room at the hospital (446 Bellevue Avenue in Trenton). This is part of the "circuit riding educational program" sponsored by the New Jersey Chapter of the American Academy of Pediatrics and cosponsored by Mead Johnson, Ciba, and Schering.

Medical Program in Baltimore

The Medical and Chirurgical Faculty of Maryland announces its 174th Annual Meeting at the Baltimore Civic Center, May 3, 4, and 5, 1972. There is no registration fee and credit for attendance is given by the AAFP. A varied program with a star-studded faculty has been provided. For more details, write to Mr. John Sargeant, Medical-Chirurgical Faculty, 1211 Cathedral Street, Baltimore 21201.

Clinical Application of Basic Sciences

The final series in the Burlington County Memorial Hospital programs (supported by Merck, Sharp, and Dohme) on "Clinical Application of Basic Sciences" will be held during the month of May. All sessions convene at 3:30 p.m. in the T. J. Summey Building of the Hospital. The American Academy of Family Practice allows one and a half credits per session. For further information please contact the hospital directly (175 Madison Avenue, Mount Holly).

May 4 Syndrome of Stress Ulcer
May 11 Zollinger-Ellison Syndrome
May 18 Drug Interactions
May 25 Anticoagulants and Fibrinolytic Agents

Cancer Chemotherapy

A conference on cancer chemotherapy, sponsored by the American Cancer Society and the National Cancer Institute, will be held on June 1 to 3, 1972, at the Biltmore Hotel in New York. This seminar will bring to the medical and related professions the most recent advances in the clinical application of chemotherapeutic agents in the management of cancer. For further information, please write to Sidney L. Arje, M.D., American Cancer Society, 219 East 42nd Street, New York 10017. There is no registration fee, but preregistration is requested.

Occupational Health Meeting

The next AMA Congress on Occupational Health will be at the Drake Hotel in Chicago on September 11 and 12, 1972. For details write to Henry F. Howe, M.D., Council on Occupational Health, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

Rheumatology: A New Subspecialty Board

The American Board of Internal Medicine has established a new subspecialty area—rheumatology. First examination for certification by the new board will be held October 17, 1972. In accordance with this, the American Rheumatism Association announces a review course in Dallas, Texas on Saturday, June 10, 1972. This is in connection with the annual meeting there of the American Rheumatism Association. For details about either the course or the examination, write to Arthritis Foundation, 1212 Avenue of the Americas, New York 10036.

Camp for Diabetic Children

Applications are now being accepted for Camp Nejeda, a special camp for diabetic children (5 to 15 years of age) at Stillwater, New Jersey. This camp has a unique medical and safety record. If you have any diabetic children among your patients, write to the New Jersey Diabetes Association, 317 Belleville Avenue, Bloomfield 07003, for a brochure or application form. Children are accepted regardless of their ability to pay.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

April

10 **Academy of Medicine of New Jersey**
Saint Francis Health Center
Jersey City
Proper Use of Antibiotics

12 **Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: Implantology

12 **Bergen Pines County Hospital**
Paramus
Control Mechanisms in Intestinal Motility

12 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Throat Cultures in Practice

13 **Burlington County Memorial Hospital**
Mount Holly
Thermography

13 **Fair Oaks Hospital**
Summit
Behavior Therapy

19 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
Leukemia and Lymphoma

19 **Bergen Pines County Hospital**
Atlantic City
ACP Meeting

19 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Clinical Aspects of Allergy

20 **Burlington County Memorial Hospital**
Mount Holly
Radiography in Evaluation of Gastrointestinal Diseases

22 **American Cancer Society**
Rutgers Medical School, Piscataway
Role of Primary Physician in Cancer Patient

25 **Academy of Medicine of New Jersey**
Warren Hospital
Phillipsburg
Current Burn Treatment

26 **Bergen Pines County Hospital**
Paramus
Ulcer Disease

26 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Hodgkins Disease

26 **Newark Eye and Ear Infirmary**
Annex Building, Newark
Observations in China

27 **Burlington County Memorial Hospital**
Mount Holly
Diseases of the Esophagus

27 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

27 **Fair Oaks Hospital**
Summit
Behavior Therapy

May

3 **Bergen Pines County Hospital**
Paramus
Intravenous Hyperalimentation

3 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Surgical Indications in Thyroid Disease

4 **Burlington County Memorial Hospital**
Mount Holly
Syndrome of Stress Ulcer

6-9 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

10 **Bergen Pines County Hospital**
Paramus
Use and Abuse of Digitalis

10 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Soft Tissue Tumors

11 **Burlington County Memorial Hospital**
Mount Holly
Zollinger-Ellison Syndrome

11 **Fair Oaks Hospital**
Summit
Brain Tumors

17 **Bergen Pines County Hospital**
Paramus
Malabsorption Syndrome

17 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Surgery for Coronary Artery Disease

18 **Burlington County Memorial Hospital**
Mount Holly
Drug Interactions

18 **Academy of Medicine of New Jersey**
Mayfair Farms, West Orange
Annual Awards Dinner

24 **Bergen Pines County Hospital**
Paramus
Immunoglobulin Disorders

24 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Colon and Rectal Carcinoma

25 **Burlington County Memorial Hospital**
Mount Holly
Anticoagulants and Fibrinolytic Agents

25 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting X-rays of the Month

25 **Fair Oaks Hospital**
Summit
Medical Aspects of Drug Abuse

31 **Bergen Pines County Hospital**
Paramus
Emphysema

31 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building Newark
Courtroom Confrontation

June

7 **Bergen Pines County Hospital**
Paramus
Surgery in Coronary Artery Disease

8 **Fair Oaks Hospital**
Summit
Psychiatric Sociology


In the glaucoma patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported



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(ISOXSUPRINE HCl)
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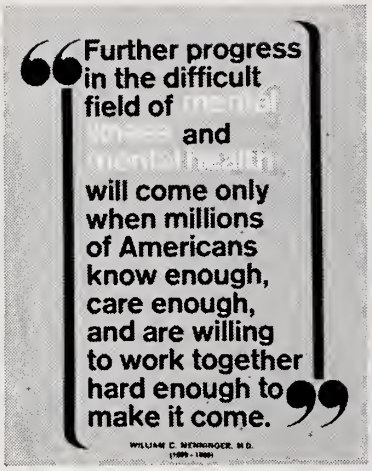
- no reported increase of intraocular pressure.
- conflicts have not been reported with diuretic corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, diabetes, peptic ulcer or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, sever investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been den onstrated both by objective measurement[2,4] and observation of clinical improvement. Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascul diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebi conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteri sclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 m and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Caution There are no known contraindications to recommended oral dosage. Do not give imm diately postpartum or in the presence of arterial bleeding. Side Effects: Occasional pa pitation and dizziness can usually be controlled by dosage reduction. Complete deta available in product brochure from Mead Johnson Laboratories. References: 1. Clar son, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. I and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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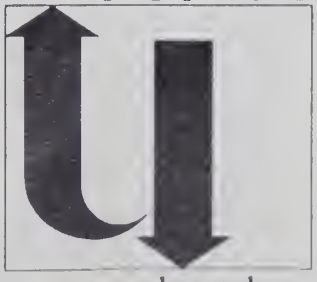
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Non-narcotic

CEROSE-DM® for relief of coughs due to colds. It diminishes the cough reflex, promotes expectoration, and provides effective vasoconstriction and bronchodilatation. Contains non-narcotic dextromethorphan

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Prescribing Informotion — Composition: Eoch white, beveled, compressed toblet contoins: Quinine sulfote, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention ond treotment of nocturnol ond recumbency leg muscle cromps, including those ossocioted with orthritis, diobetes, voricose veins, thrombophlebitis, orteriosclerosis ond stotic foot deformities. **Controindicotions:** Quinomm is controindicoted in pregnoncy becouse of its quinine content. **Precoutions/Adverse Reactions:** Aminophylline moy produce intestinol cramps in some instonces, ond quinine moy produce symptoms of cinchonism, such os tinnitus, dizziness, ond gostrointestinol disturbonce. Discontinue use if ringing in the eors, deofness, skin rosh, or visuol disturbonces occur. **Dosoge:** One toblet upon retiring. Where necessory, dosoge moy be increosed to one toblet following the evening meol ond one toblet upon retiring. **Supplied:** Bottles of 100 ond 500 toblets.

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LETTERS TO THE JOURNAL

(The following exchange of letters between one of our members and Commissioner of Health Cowan is here published as a matter of interest to our profession. —Editor)

Testing Not Enough?

December 23, 1971

Dear Dr. Cowan:

For some time now, I am encountering more and more patient resistance for premarital examination for syphilis as required by law. There is no problem regarding blood serology other than the fact that some laboratories in Camden County perform them without a request slip from a physician and even give the applicants the marital certificate for his signature.

It is my understanding that for detection of early syphilis and gonorrhea or other venereal disease the marriage applicant is to be examined and have, in addition, a serological blood test for syphilis. This is the bone of contention! The public is not made aware of this by laboratories, both hospital and private, and by municipal clerks. The applicants merely are told that all that is necessary to get married is to have a blood test and have the physician *sign* the marital form. When it is explained by me that it *also* requires an examination for presence of communicable or infectious syphilis they *resent it.* They drop me as their family physician, or go to other doctors who readily sign them and tell them that such examination is *not necessary!*

The examination I have made for the past 25 years of practice designed to rule out VD in infectious forms in the male is: visual inspection of the mouth and mucous membranes, a check of pupils of eyes, visual inspection of skin of body and extremities, and visual inspection of genitalia and anus.

For the female, it is the same except for pelvic examination which consists of visual inspection of external genitalia and anus and, if hymen is absent, visual inspection of cervix and vagina with use of speculum.

My fee for this is a simple office call of $7 to $10 per applicant, contingent on amount of work performed and if premarital counseling is included.

Have I been wrong in my interpretation of the law as written on the marital medical certification? If so, then please send a directive out to all physicians who are making a similar mistake! If not, then please send a directive to all municipal borough clerks, physicians, hospital laboratories, and private laboratories informing them of the *necessity* of a physical examination by the physician of marriage applicants, in addition to serological testing.

This is by and large *not being done,* and it places the conscientious physician who does it in a difficult position with his patients, and subjects him to unfair criticism.

The physician must have some official form in print from the State to back up his stand in premarital examination, or let us rescind the law as now written and merely accept the blood serology report for syphilis and then sign the form without further examination, or revise the wording of the premarital certificate issued by the State as regards the physician's examination, and the laboratory's report.

(signed) Vincent S. Palmisano, M.D.

The Commissioner Replies

January 14, 1972

Dear Dr. Palmisano:

I am writing in reply to your letter of December 23, 1971, concerning premarital examinations for syphilis.

You are quite right in your statement in the letter that the law presently requires an examination, as well as the performance of a

serologic test for syphilis. An examination such as you described that you do in your office is in compliance with the law as it now exists in New Jersey.

I think there is real question in the minds of many physicians and public health officials as to the usefulness of the present premarital laws for the detection of venereal disease. This is a problem that is presently under examination by our Department but we would welcome the considered advice of others interested in this subject. We think it might be very appropriate for the Medical Society to look into the problem of the relevance of our present premarital examination laws to the detection of venereal disease and to consider recommendations for changes in the law, if so indicated. Our Department would be most interested in working with any groups that are considering these laws, in addition to the evaluation that we are doing ourselves.

You have indicated to members of our Department that you have been in contact with the Camden County Medical Society and The Medical Society of New Jersey concerning this matter. It is our hope that appropriate members of either Society would contact our Department if there is interest in further evaluation of our present laws concerning premarital examinations and testing.

(signed) James R. Cowan, M.D.
Commissioner of Health

Physician as a Social Activist

January 15, 1972

Dear Sir:

The editorial, "Not All Health is a Medical Problem," in your issue of January 1972 deserves comment.

To say that poor nutrition, bad sanitary engineering, cigarette smoking, and automobile accidents are beyond meaningful control of the physician smacks of a pusillanimity not in keeping with the classical standards of our profession.

Much of our work is devoted to the correction, control, or alleviation of the end-stages of chronic disease. This we do daily with such common problems as atherosclerosis or cancer. However, the concerned physician should not be satisfied merely to ease the lot of those who have suffered an auto accident or are coughing from cancer of the lung. No more would he be satisfied to treat the case of paralytic poliomyelitis or to ease the breathing of the diphtheritic child. More meaningful work is done when we give our patients preventive immunizations.

So it is the physician's duty to ally himself with those who are developing "shots" for these conditions. There are organizations like the American Heart Association and the American Cancer Society and others, which strive to provide better drivers and safer automobiles and better nutrition for all.

Remember that it is in our highest tradition not to wring our hands helplessly or hopelessly during the epidemic of cholera. It is still possible to steal the handle from the Broad Street pump.

(Signed) Leo Lewin, M.D.

Good idea, but how can the M.D. *make* people stop smoking or eat a more balanced diet?—Editor.

A Plea for Vision Training

January 17, 1972

Dear Sir:

I have been reading *The Journal* for the past four or five years. Quite frankly, I have found the editorials most rewarding. Recently, I have noticed that leading medical papers and magazines throughout the country have quoted *The Journal.* My admiration is shared by many. Even when a tinge of bias tainted the pages of *The Journal* I did not change my opinion. When one is the only optometrist in a family of physicians and dentists bias becomes a by-product of a way of life. One learns to deal with it to survive.

It is my belief that you have performed a great disservice to the physicians of this state. On page 75 of the January 1972 issue of *The Journal,* an article entitled "The Eye and Learning Disabilities" was not only tinged and tainted but also deliberately misleading.

Through the clever use of words the physician is led to believe that vision training is without merit. If that is the case then many reputable hospitals, clinics, and universities around the country would have to close their vision departments. Great names in clinical research would lose their place in medical history, not only in the United States, but also in Germany, France, and England.

I could present a point-by-point rebuttal. Instead, I enclose an article which, though poorly written, contains some background material on vision training. The most important part of the article is the reference list. Eight of the twenty citations are physicians or physician assistants. I find it very difficult to believe that these people or the people to whom they refer are to be denied their life's work for so obvious a political ploy.

I wish you continued editorial success in this new year and hope you will not again take part in derisive displays of professional schizophrenia.

(signed) Joseph R. Miele, O.D.

The article to which Dr. Miele refers appeared in the October 1971 New Jersey Journal of Optometry. Reprints are available from Dr. Joseph Miele, 36 Cherry Tree Farm Road, Middletown, New Jersey 07748—Editor.

OBITUARIES

Dr. Carlos Benavente

Born in 1923, Carlos Benavente died at the age of 48 on Christmas Eve, 1971. He was a 1950 graduate of the medical school at Lima, Peru, and was a member of our Hudson County Medical Society. Dr. Benavente was a general surgeon, and a Fellow of the American Society of Abdominal Surgeons. He was affiliated with the North Hudson Hospital in Weehawken and practiced in Union City, New Jersey.

Dr. Abraham Goldfarb

A 1930 alumnus of the Jefferson Medical College, Abraham Goldfarb, M.D., died on January 24, 1972 at the age of 67. From 1942 to 1946 he was a commander in the medical corps of the U.S. Navy. He had been affiliated with Bergen Pines in Paramus and with the Valley Hospital in Ridgewood. Dr. Goldfarb was board certified in obstetrics and gynecology, was a Fellow of the American College of Obstetrics and Gynecology and of the American College of Surgeons, and was a member of our Bergen County Component Society.

Dr. Joseph Grundorfer

Director of the blood bank at the Newark Beth Israel Medical Center, Joseph Grundorfer, M.D., died on December 26, 1971. Born in Vienna in 1905, he was an alumnus of the medical school of the University of Vienna, class of 1933. He practiced in his native Austria from 1933 until 1944 when he came to the United States and settled in New Jersey. He was a pathologist and a Fellow of the Academy of Medicine of New Jersey.

Dr. M. Browne Holoman

M. Browne Holoman, M.D., formerly chief of proctology at the Atlantic City Hospital and at Shore Memorial Hospital in Somers Point, died on February 16, 1972, at the age of 68. He received his M.D. at Syracuse in 1930. During World War II, he was a major in the Medical Corps of the Army of the United States. He was attending surgeon at the Burdette Tomlin Hospital in Cape May, and was active in the Pennsylvania Society for Rectal Surgery. Dr. Holoman retired from active practice in 1963.

Dr. Charles H. Jackson

One of southern New Jersey's senior physicians, Charles H. Jackson, M.D., died on February 5, 1972, at the grand age of 89. He had been chief of medicine at the West Jersey Hospital in Camden. He was a 1905 alumnus of the Hahnemann Medical College, and a pioneer in the development of the New Jersey chapter of the American Academy of Family Practice. Dr. Jackson was a member of our Camden County Component Society.

Dr. Arthur M. Jenkins

Born in 1904, Arthur M. Jenkins, M.D., died on February 8, 1972. He was a 1936 alumnus of the Medical School at Duke University. He was 32 years old by the time he received his M.D. degree, having been a physical education instructor at the Frenchtown schools for a number of years before he entered medical school in 1932. Dr. Jenkins was a general practitioner, active in the affairs of the American Academy of Family Practice and affiliated with the staffs of the Hunterdon County Medical Center in Flemington and the Warren Hospital in Phillipsburg.

Dr. Nathan Lobsenz

Long active in Passaic County medical affairs, Nathan P. Lobsenz, M.D., of Paterson, died on January 29, 1972. He was a 1915 Bellevue graduate and was prominent in the field of ophthalmology and otolaryngology, being board certified in both specialties. He was on the staffs of St. Joseph's and Barnert Memorial Hospitals, both in Paterson, and was also active in his chosen field at the Passaic Beth Israel Hospital.

Dr. E. Harrison Nickman

One of our state's most active medical citizens, E. Harrison Nickman, M.D., died on February 26, 1972, at the age of 69. A Maryland 1929 graduate, he was board certified in pediatrics and had served as President of the Staff at the Atlantic City Hospital, where he had also been Chief of Pediatrics. He was instrumental in a study of water supplies in southern New Jersey. He established the Atlantic County Medical Journal, of which he was the first editor. He was active in promoting music and arts festivals in Atlantic County, and had a tour of duty as President of our Atlantic County Medical Society.

Dr. Robert Peterman

Word has just been received of the death, on October 31, 1971, of Robert Peterman, M.D. Dr. Peterman formerly did clinical research in biochemistry at Merck, at Pfizer, and at Roche Laboratories. Since 1970 he has maintained a private practice in Nutley. He served for twenty years as the physician in charge of New York City's nutrition clinic, and was a lecturer in clinical nutrition at Columbia University's School of Public Health during 1969 and 1970. Dr. Peterman was only 58 years old at the time of his death. He had received his M.D. from Temple in 1938, and had served as a major for five years in the Army Medical Corps in World War II. Dr. Peterman was a member of the Passaic County Medical Society, and a Fellow of the American Public Health Association, the American College of Nutrition, and the American Geriatric Society.

Dr. Samuel A. Sandler

One of our State's best-known neurologists and psychiatrists, Samuel A. Sandler, M.D., died on February 3, 1972 at the age of 78. He was board certified in both psychiatry and neurology, and for years he was senior attending neuropsychiatrist at the Hackensack

Hospital. He served in both world wars, as an artillery sergeant in 1917 and as a lieutenant colonel in the medical corps from 1942 to 1945. Dr. Sandler was a graduate of the Medical School at the University of Kansas, class of 1929, and was a member of our Bergen County Medical Society.

Dr. Chih E. Teng

An anesthesiologist on the staff of St. Elizabeth's Hospital in Elizabeth, New Jersey, Chih E. Teng, M.D., died on January 3, 1972, at the age of 64. She was graduated in 1934 from the medical school of the Shantung Christian University in China. She worked in the anesthesia department of several New York Hospitals before coming to our state in 1966. Dr. Teng was a member of our Union County Medical Society.

Dr. Lucius Tarchiani

An alumnus of the medical school at the University of Paris (France), Lucius S. Tarchiani, M.D., died on January 28, 1972 at the age of 63. He was a general practitioner, of the kind usually identified as a "family doctor of the old school." Dr. Tarchiani lived in Paterson and was active in the affairs of our Passaic County Medical Society. He was affiliated with the Passaic Beth Israel Hospital.

Dr. Frank B. Vanderbeek

Born in 1911, Frank B. Vanderbeek, M.D., died of a massive stroke on February 25, 1972. He was a prominent ophthalmologist and otolaryngologist in Passaic County, having been board certified in both specialties. His M.D. came from Columbia University's College of Physicians and Surgeons in 1936. In 1960, he was President of the Medical Board of Paterson General Hospital, an institution which he had served in ophthalmology and otolaryngology for many years. He also had long service as Chairman of the Committee on Conservation of Vision of The Medical Society of New Jersey. He served our Society in numerous liaison positions within his chosen field. At one time he was Treasurer of the Passaic County Medical Society.

Dr. Ralph A. Warwick

Born in 1904, Ralph A. Warwick, M.D., died on February 5, 1972. For many years he was chief of pediatrics at the West Jersey Hospital in Camden. He was an early diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, and headed up the medical staff of the Camden Home for Friendless Children. He was a 1928 alumnus of the Hahnemann Medical School, and during World War II, was a lieutenant colonel in the Army of the United States.

Dr. William V. Young

At the untimely age of 54, William V. Young, M.D., died on January 20, 1972. Dr. Young was attending pathologist at both the Point Pleasant Hospital and the Jersey Shore Medical Center. He also was the County Physician for Ocean County. A Long Island alumnus, class of 1942, he was a medical officer in the U.S. Navy during World War II. He was board certified in pathology and had his residences at the Mountainside Hospital in Montclair and at the New York Postgraduate Hospital. He was a member of our Ocean County Medical Society, and had a tour of duty as a member of the Board of Education at Point Pleasant.

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They Merit Your Support

Diagram of a drug abuser



Redness and watering of eyes
—glue sniffing

Red, raw nostrils
—sniffing cocaine

Running nose
—heroin, morphine, codeine

Profuse perspiration and body odor
—amphetamines

Constant licking of lips
to keep them moist
resulting in chapped raw lips
—amphetamines

Long sleeve garments worn constantly
to hide needle "tracks"
—heroin or methedrine

Drastic loss of weight
—heroin, opium

Tremor of hands
—amphetamines

Sunglasses worn at
inappropriate times and places
hiding dilated pupils—LSD

Staggering, disoriented
—barbiturates

These are a few of the signs that may indicate that a young person could be abusing drugs or using narcotics. While these symptoms are not proof of drug abuse (most could occur for several other reasons), they should serve to alert parents and friends that a problem may exist.

If you're not sure, talk with your family physician. If you suspect, ask your child point blank, "Are you taking drugs?"

It's a sad thing to have to ask someone you love, but saying "Goodbye" is even sadder still.

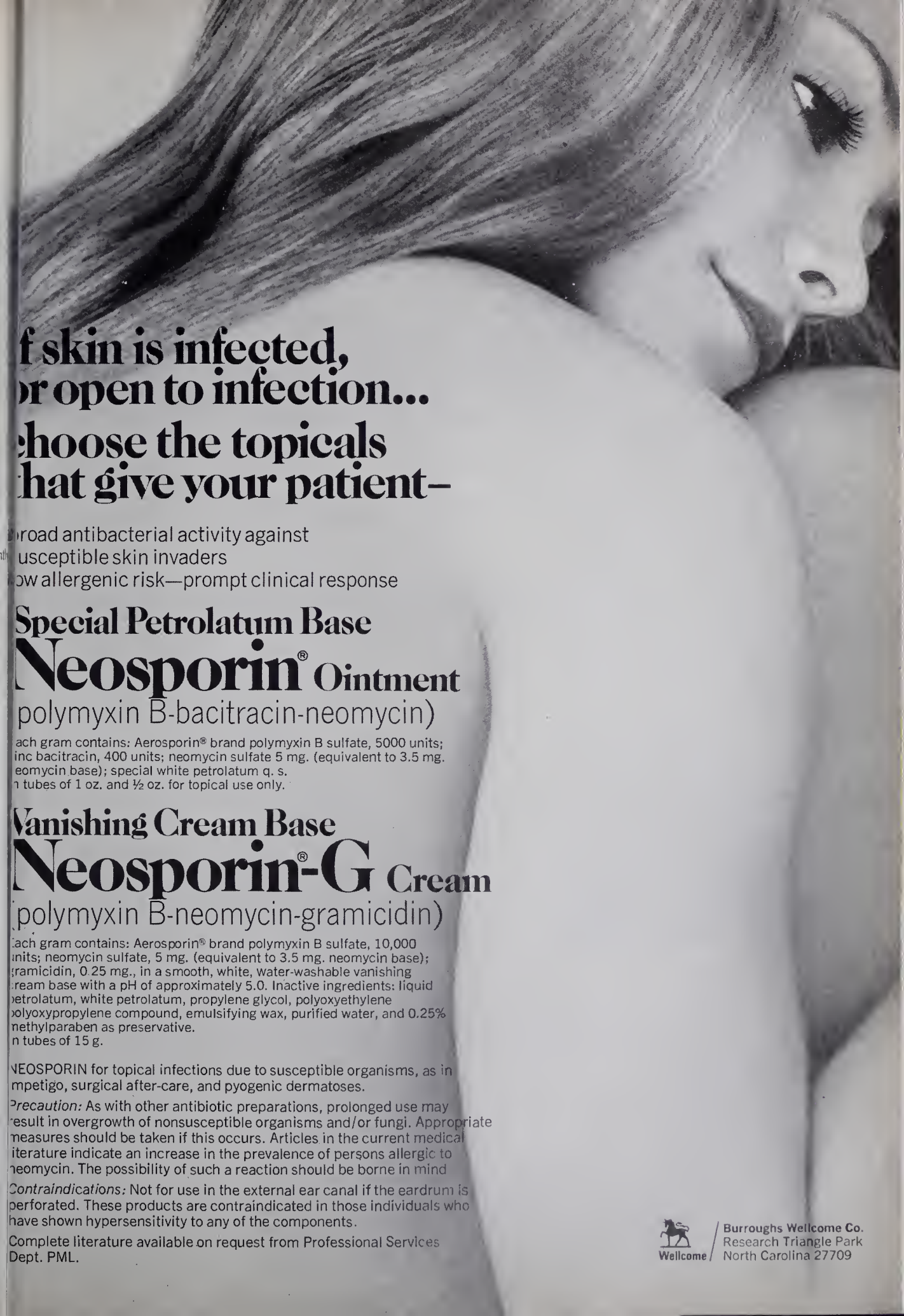
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SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA. Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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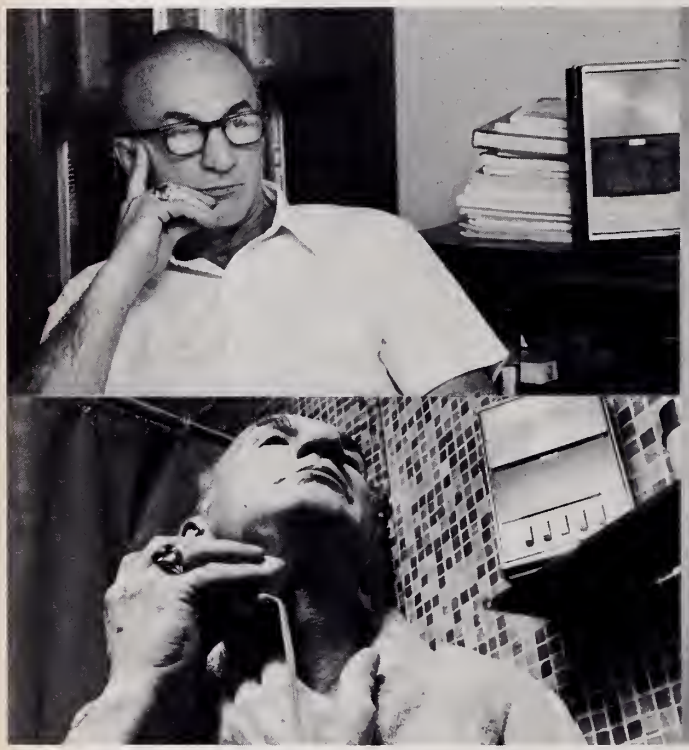
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BOOK REVIEWS

The Great Doctors. Henry E. Sigerist. New York, Dover Press, 1971. Pp. 436. Illustrated. (Softback—$4.50)

The Great Doctors is an attempt on the part of a distinguished medical historian to present the history of medicine from its mythologic, legendary origins to the early twentieth century through brief biographic sketches of nearly fifty prominent medical scientists. The original German edition was published in 1933, and has been translated into highly literate English. The fifty biographies have been interestingly written, but it was not possible to present anything more than a superficial review of the contributions of fifty men in less than 400 pages. Perhaps twenty "great men" could have been eliminated, and thus have permitted a more meaningful description and explanation of the development of medical thought and progress through the lives of thirty "great men." The task of trying to achieve unanimity of opinion or even a consensus concerning the relative merits of thirty out of fifty medical scientists would be more difficult today in our present era of specialization than in 1933, because the members of a given specialty would have a greater comprehension of and appreciation for a particular contributor to the advancement of a particular specialty.

Since the author concluded his work prior to the advent of specific chemotherapy (with the exception of Ehrlich's arsenicals), it was not possible to provide a description or explanation of the great revolution in clinical medicine initiated by effective chemotherapy and antibiotic therapy. It might be unfair to the author to note the absence of any explanation of the apparent slow progress of medical scientific thought and practice during the centuries of relatively rapid progress in the physical sciences since the achievements of the late nineteenth and early twentieth centuries may have seemed tremendous and monumental in 1933. This reviewer fails to discern anything meaningful served by the re-publication of this 1933 work, except possibly to appreciate the problems and obstacles that confronted the "great men" of medicine trying to grasp and implement new ideas.

Jerome Abrams, M.D.

The V.D. Story. Stewart M. Brooks. Cranbury, New Jersey, A. S. Barnes, 1971. Pp. 162. Illustrated. ($5.95)

To write a book on a scientific subject, in this case venereal disease, with an attempt to please both the physician and the layman is not easy. The author of this volume did not succeed. The idea of spending almost six dollars to learn what every physician should know (with technical detail that a non-physician would not remember) seems to be a waste of money. The author repeats himself in different chapters and uses a style of writing that fails to hold reader interest. He manages to make an interesting subject sound dull. Mr. Brooks has more talent than is evidenced by this book, but then we all have our bad days. Not recommended.

Gerard F. Hansen, M.D.

Old Age: The Last Segregation. Claire Townsend. New York, Bantam Books, 1971. Pp. 228. (Softback—$1.95)

In 1970, a group of college women made a study of nursing homes for the aged, under Ralph Nader's general supervision. The panel feels that most such homes are, as they put it, "profit-oriented" and point out that the more patients they can bed down, the more profit. They see an overuse of medication, unjustified neglect by attending physicians, a deplorable lack of staff and physical facilities, poor food, and general callousness toward patients. Most nursing homes, the author asserts, fail to meet state and federal standards. Many of these homes require "irrevocable" contracts whereby the patients turn over to the institution all their assets including life insurance policies. If the guest subsequently leaves the nursing home, he may have to abandon his assets—even the right to change the beneficiary on the insurance policies.

The panel charges that pharmacies often give "kickbacks" to nursing home administrators as a requirement of getting their business. Some well-intended nursing home practices are described as infantilizing the patients. Difficulties are especially worsened in rural areas.

The task force finds that Scandinavia and Great Britain have handled the problem with more intelligence and dignity than we have in the USA. They are particularly impressed with their effort to find non-institutional placements for the elderly sick. The book concludes with seven recommendations, spelled out in usable detail. These are: (1) more emphasis on preventive medicine and rehabilitation; (2) publication of quality ratings for nursing homes; (3) better training of aides and attendants; (4) licensing of administrators; (5) development of non-institutional alternatives; (6) more conscientious medical review; and (7) more rigorous enforcement of federal standards. On the whole, this is a disturbing book and one not designed to make us proud of our profession or of our approach to the problem of the aged in a youth-oriented society.

Abraham Leff, M.D.

Rehabilitation Medicine (Third Edition). Howard Rusk, M.D. St. Louis, Mosby, 1971. Pp. 687. Illustrated. ($21)

Rehabilitation medicine is of great value when used intelligently. A clear understanding between physician, therapist, and patient as to the goals to be sought in each case, and the indications for the various technics available results in efficient and effective utilization of the modalities.

This excellent text should be read by anyone who refers patients to rehabilitation departments or facilities, whether for the "simple" devices such as crutches and walkers, or for major restorative care. The chapter on prescription writing is particularly helpful.

After presenting the principles of rehabilitation medicine, including all of the various skills involved in the term (not only physical therapy), chapters are devoted to rehabilitation of patients with a wide variety of disabling conditions, including pulmonary and vascular, as well as neurologic and musculoskeletal.

This text should be in the library of every hospital which provides rehabilitation services of any scope. The organization of the book is excellent, the illustrations are clear, and a complete bibliography is provided.

Daniel J. O'Regan, M.D.

Lumbar Disc Disease: A Twenty-Year Clinical Follow-up Study. Blaine S. Nashold, Jr., M.D., and Zdnenek Hrubec, Sc.D., Editors. Saint Louis, Mosby, 1971. Pp. 139. Illustrated. ($16.50)

In 1934 Mixter and Barr elucidated the role of the herniated disc in the etiology of sciatica. Since then the merits of conservative versus surgical treatment have been debated. Additionally, the role of spinal fusion (either combined with disc excision as a primary procedure or as a secondary procedure) further stimulates controversy. Now, this book comes along and at first it seems that it will bring us statistical evidence to support or challenge our notions. In this the reader is disappointed.

The book offers a retrospective study of 1,123 patients with lumbar disc disease originally treated in the military during 1944 and 1945 and subsequently re-evaluated some 20 years later. Of this number, 395 were treated surgically (only 12 of these had fusion); the rest were treated conservatively.

The book is loaded with tables filled with details such as: presenting complaints, laterality and severity of symptoms, physical findings, and modes of treatment. The appendix of 34 pages contains copies of worksheets, follow-up letters, and other minutia of little value to the clinician. A bibliography of 26 pages is probably the most complete yet compiled on this subject.

No clear guidelines for treatment emerge. As stated in the final summary, it raises more questions than it answers and its value perhaps is in reiterating that each case is new unto itself. But, 139 pages at $16.50 seems too high a price for this insight, even in these inflated times.

Peter Carbonara, M.D.

Symposium on the Functional Physiopathology of the Fetus and Neonate-Clinical Correlations. Edited by Harold Abramson, M.D. Saint Louis, Mosby, 1971. Pp. 182. Illustrated. ($15.00)

Here are the transactions of a symposium of the Special Committee on Infant Mortality of New York County in February 1970. It includes an interesting compendium on diagnosis and detection of genetic disorders before and after abortion and delivery. The book is concise, well-written, and thoroughly up-to-date. The bibliography is most complete. Of particular interest are the chapters on the environmental effect of drugs, radiation, and other physical agents, as well as of immunologic factors upon the fetus and neonate. Special emphasis is placed upon differential diagnosis in detecting these factors. The chapter on chromosome aberrations is most instructive although it presupposes a basic knowledge of genetics and the possible mutations. The outer make-up (clear print, good illustrations, and durable binding) is excellent though $15 for 182 pages seems a little steep.

The book will appeal to obstetricians, pediatricians, and genetecists as well as researchers since it contains a wealth of information in synoptic form. It is highly recommended.

The only detectable flaw is the failure of dealing with the *management* of "high-risk" pregnancies once the diagnosis of an impending genetic catastrophe has been made. The interruption of such pregnancy seems to be the only logical conclusion to save the parents untold headache, heartache, and unnecessary financial burden. It is hoped that this text may serve as a guideline for legislative committees charged with the revision of abortion laws (outside of a handful of states in which they have been revised). These legislators could derive the latest stand of science on the transmission of hereditary diseases and, by enacting a more realistic statute, they would render an inestimable service, not only to their constituents but to the nation as well. This book stresses the early recognition of fetal abnormalities (thalidomide babies, future mongoloids, and babies of mothers exposed to noxious viruses or radiation during the first months of pregnancy), and it is high time that these should be included in the indications for abortion if the mother requests it.

Werner Steinberg, M.D.

Use of Lithium in Psychiatry. Barry Maletzky, M.D. and Paul Blachly, M.D. Cleveland, Ohio, Chemical Rubber Company Press, 1971. Pp. 79. ($10.50)

For the patient in manic excitement, lithium carbonate appears to be the safest and most effective treatment. It is an inexpensive salt, and the authors of this text suggest that since pharmaceutical companies can't make much profit from lithium, they have not invested much in controlled research. Lithium has more calmative influence than the standard phenothiazines and has the advantage of not making the patient seem "doped up." There has long been concern about the potentially toxic effects of large doses of, or prolonged use of, lithium, but as the writers here point out, the cardiac patient can be harmed more by the excitement of his overactivity than by the fluid-retaining features of lithium. It is, however, a fact that the burden of excreting lithium falls largely on the kidney.

There is some evidence that lithium has antidepressive and even anti-schizophrenic effects, but, by and large, lithium finds its major usefulness in the manic patient. It is not effective in alcoholism. It may take from 5 to 20 days for the medication to exercise full effect, and it should not be abandoned until the clinical trial has lasted at least three weeks, unless toxic effects develop. It is best given in oral form, and is generally avoided in patients who have to be on low salt diets.

This slim monograph packs an enormous amount of useful information in its 80 pages, and tells its story in a highly practical way. The book carries one of the strangest caveats I have ever seen in a medical text—". . . the author and the publisher cannot assume responsibility for the validity of all materials or for the consequences of their use."

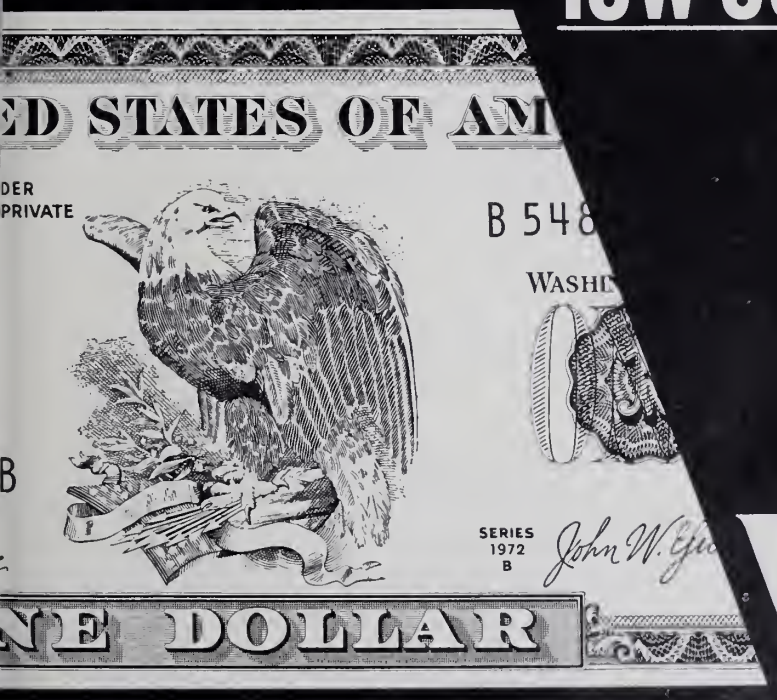
Victor Huberman, M.D.

Doctor and Patient and the Law (Fifth Edition). R. Crawford Morris and Alan R. Moritz. St. Louis, Mosby, 1971. Pp. 554. ($24.50)

In 1943, the late Louis J. Regan, M.D., LL.B., published the predecessor of this volume. Its republication and modernization are evidence of its usefulness. It is an almost encyclopedic volume, covering systematically the physician's rights and legal duties, the nature of medical testimony, malpractice litigation, forensic psychiatry, the medical witness, and confidential communications. A set of model bylaws for medical societies is included, as is the entire text of the AMA's "Principles of Medical Ethics." A malpractice preventive program is detailed. All statements in the text are carefully footnoted to the relevant case citations. All in all, this is a useful one-volume guide through the legal thicket of medical jurisprudence.

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Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

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If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, nay occur and may mimic acute neurologic disorders such as erebral thrombosis. Certain factors such as hepatic and renal isease, malnutrition, advanced age, alcohol ingestion, and drenal and pituitary insufficiency may predispose to hypoglyemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine xidase inhibitors, phenylbutazone, bishydroxycoumarin, and henyramidol may prolong or enhance the action of Orinase and ncrease risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

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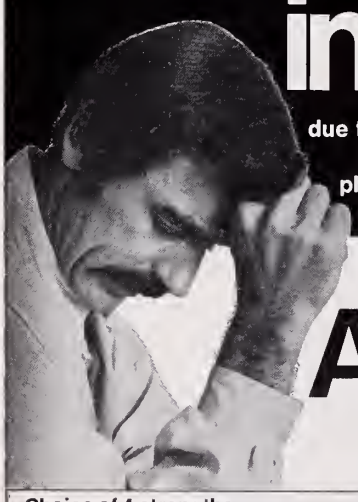
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References: 1. Monteleone, P., and Evengelisto, I. Methyltestosterone-thyroid treatment of actual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tiratt, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hattman, L., Bradlaw, H. L., Zumaff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteramic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Caltan, S. W. Effects of L-thyroxine and isothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lipoincott, Philadelphia, 1955, p. 1432. 7. Warshuk, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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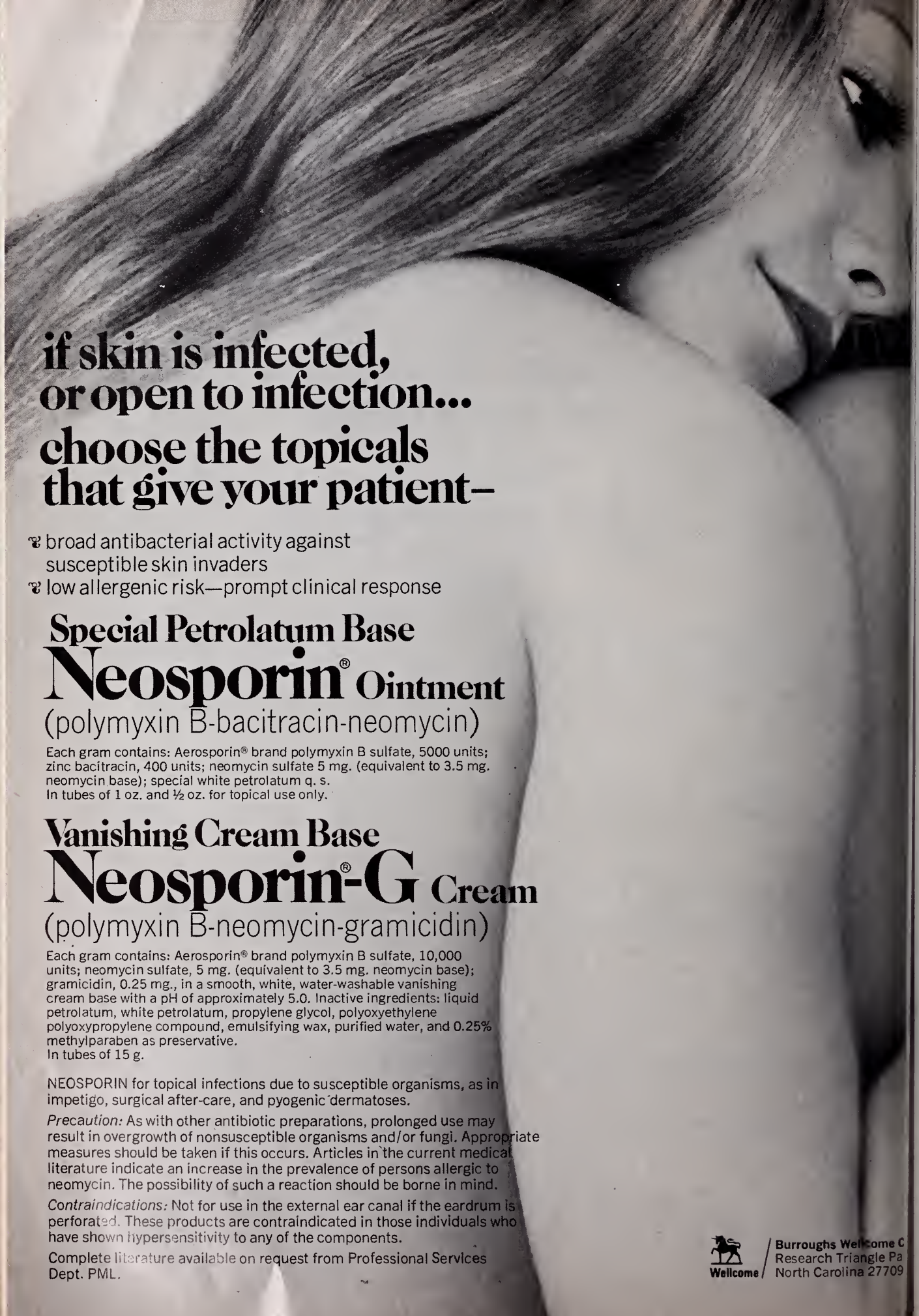
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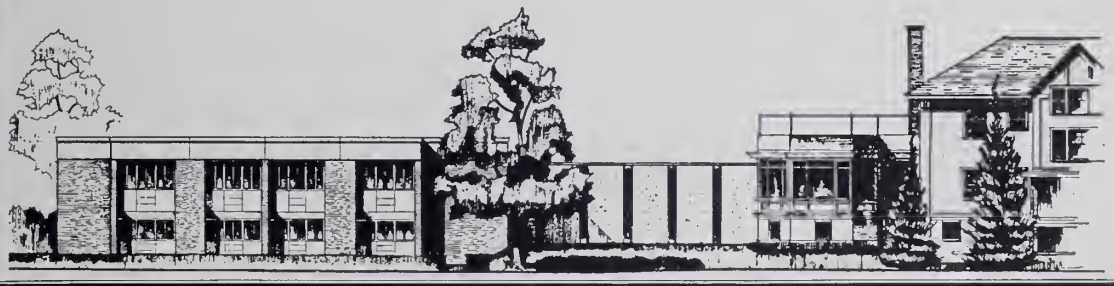
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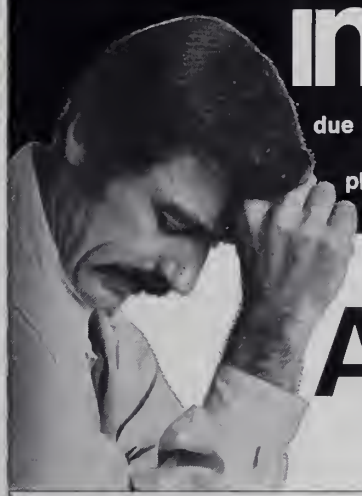
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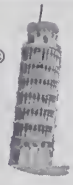
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May 1972

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mportant Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief ot severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceretion including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Cerefully Instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic enemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyluree, end sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished et regular intervals: Careful detailed history for diseese being treated and detection of earliest signs of adverse reections; complete physicel examination including check of patient's weight; complete weekly (especially for the eging) or an every two woek blood check; pertinent laboratory studies. Ceution petients about particlpeting in activity requiring elertness and coordination, es driving a car, etc. Cases of leukemie have been reported in patients with a history of short- and long-term therepy. The majority of these petients were over forty. Remember thet erthritic-type pains can be the presenting symptom of leukemie.
Adverse Reactions: This is a potent drug, its misuse can lead to serious results. Review detailed intormetion before beginning therepy. Ulceretive esophegitis, acute end reectiveted gastric and duodenal ulcer with perforation end hemorrhege, ulceration and perforation of large bowel, occult G I. bleeding with anemia, gastritis, epigestric pain, hematemesis, dyspepsie, nausea, vomiting and dierrhea, ebdominel distention, egranulocytosis, aplestic anemia, hemolytic anemie, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pencytopenie, leukemia, leukopenia, bone merrow depression, sodium and chloride retention, weter retention end edeme, plesma dilution, respiratory alkelosis, metebolic acidosis, fatal end nonfatel hepetitis (cholestesis may or mey not be prominent), petechiee, purpure without thrombocytopenie, toxic pruritus, erytheme nodosum, erytheme multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylectic shock, urticerie, arthralgia, fever, rashes (ell ellergic reections require prompt and permanent withdrewel ot the drug), proteinurie, hemeturie, oliguria, enurie, renel feilure with ezotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bileteral renal corticel necrosis, renal stones, ureterel obstruction with uric ecid crystals due to urlcosuric ection of drug, impeired renet function, cardiec decompensetion, hypertension, pericerditis, diffuse interstitial myocarditis with muscle necrosis, perivasculer grenulomata, eggrevation of temporel arteritis in petients with polymyalgia rhoumetice, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinel detachment, hearing loss, hyperglycemie, thyroid hyperplesie, toxic goiter essociation of hyporthyroidism end hypothyroidism (ceusal relationship not established), agitation, confusional stetes, lethargy, CNS reactions essocieted with overdosego, including convulsions, euphoria, psychosis, depression, hoedaches, hallucinations giddiness, vertigo, coma, hyporventilation, insomnia ulceretive stomatitis, selivary gland entargement
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- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®) may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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50 mg. Tablets

Talwin®

brand of **pentazocine** (as hydrochloride)

the long-range analgesic

"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications link in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn, could notify the physician in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

dvertisement

One of a series

ue

Maker of Medicine

Henry W. Gadsden, hairman & Chief Executive Officer, Merck & Co., Inc.



In my opinion, it is the esponsibility of all physiians and medical scientists o take whatever steps they hink are desirable in a law- nd regulation-making rocess that can have far- eaching impact on the ractice of medicine. Yet nany events in the recent ast indicate that this is ot happening. For exam- le, it is apparent from rug efficacy studies that he NAS/NRC panels gave ittle consideration to the vidence that could have een provided by practic- ng physicians.

There are several current levelopments that should ncrease the concern of racticing physicians about rug regulatory affairs. One s the proliferation of mal- ractice claims and litiga- ion. Another is the effort y government to establish he relative efficacy of rugs. This implies that if a physician prescribes a rug other than the "estab- ished" drug of choice, he may be accused of practic- ng something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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EDITORIALS

Unsolicited Medical Journals

From time to time there is objection to sending unsolicited medical journals to doctors. The feeling is that it would be impossible for the practitioner to read, much less to absorb, this flood of unrequested material. In the June 1971 *Journal of the Florida Medical Association,* there was an estimate that each practicing physician is getting about thirty pounds a month of unsolicited publications. However, this figure actually exaggerates a bit. The thirty pounds includes not only journals but advertisements of all sorts, and probably the regular advertising in the direct mail operation accounts for more of the tonnage than do the journals.

The *Medical Times,* issue of October 1971, has published an editorial deploring what it calls "pollution of doctors' desks" with this material, and has made its own contribution by asking readers to indicate whether they want to read that journal. The assumption would be that doctors who do not respond would be taken off the mailing list.

The problem is a real one. However, most of these journals are short, compact, and written in a generally spritely fashion. Many practitioners confess, rather shamefacedly, that they find this reading more lively than the more formal scientific medical journals. Most of these unsolicited journals are distributed, in effect, as advertisements. It may be assumed that the publishers would not continue unless they had evidence that the doctors read the material. Perhaps the solution to the problem would be to try to make our regular journals more readable. The decision of *Medical Times* to request doctors to indicate by postcard that they are reading the journal offers an interesting effort to curb this flood.

Jerome G. Kaufman, M.D. 1901-1972

He was truly one of the giants of New Jersey Medicine. The formal obituary on page 485 of this issue gives only a cold, factual account of his crowded contributions to the people and the profession of our State. He seemed eventually to become President of any organization with which he was affiliated—the State Board of Medical Examiners, the Essex County Medical Society, the Beth Israel Medical Center, and, of course, The Medical Society of New Jersey. Our Society has thus suffered two grievous losses—Dr. Jesse McCall and now Dr. Kaufman. We who must carry on can ill afford such losses.

Dr. Kaufman was a teacher. He held professorial rank at New York Medical College. He was active in civic affairs, serving, for example, on the Board of Directors of the Medical-Surgical Plan. He was a trustee of our State Society for over a decade. He was active in the Essex County Blood Bank and Vice-President of the American Heart Association. He was, with all this, the good physician, board certified in his chosen specialty, a consultant to numerous hospitals and agencies. He was an exemplar of the philosophy that if you want a job to be done right, give it to a busy man. He labored for his 46 years of active practice on behalf of his colleagues and on behalf of all the people of our community. Death must come sooner or later to all mortals, but it is written that when one dies after having lived on behalf of others, let there be no lamentation. So it will be with Jerome G. Kaufman. He indeed dedicated himself to others. We grieve but we do not lament.

Misadventure with Hexachlorophene

The Food and Drug Administration has been trying to wake up from what the Associated Press calls a "regulatory nightmare" on its

hasty ban on hexachlorophene bathing of the newborn. Specifically indicated in the FDA ruling was pHisoHex (Winthrop), a product about as well established in the health care field as shoes are in our clothing customs.

Save for the tragic consequences growing directly out of the restriction, the whole matter could be characterized as just another regulatory misadventure which, against the record of oral contraceptive scares, combination ingredients bans, and once, the labeling of a tennis shoe as a drug, should astonish nobody.

The entire point is simply this: When the preliminary and obviously inconclusive findings suggesting some degree of hazard in hexachlorophene bathing surfaced, the American Academy of Pediatrics acted promptly, decisively, and effectively to recommend measures to protect the newborn. And what's more, physicians know that they can best rely on the advice of other physicians who weigh the risk-versus-benefit ratio as only physicians can.

The HCP ban was based upon three preliminary reports: (1) Fifty newborn infants bathed with a 3 per cent HCP product in the hospital nursery were said to show blood levels of the agent of .009 to .646 mg/ml at discharge. But, incredibly, the same report stated that "no obvious toxic symptoms were noted in the newborns." (2) Rats fed (yes, it said *fed*) hexachlorophene to achieve mean levels of 1.21 mg/ml showed brain changes. (3) Newborn monkeys washed daily with a 3 per cent HCP product for 90 days showed mean plasma levels of 2.3 mg/ml and brain changes at autopsy. The scientists conducting the investigation agree that the baby monkeys were not tethered during their baths, so just how much bathwater was ingested under such circumstances cannot be known.

JAMA reported in February that staphylococci outbreaks were occurring in hospital nurseries where use of HCP had been discontinued. A few days after that *Journal* appeared, FDA held a news conference, making the tragic succession of events public. The agency argued that physicians didn't really understand what it had said in its December 6, 1971 bulletin. The other inference was that it didn't mean what it said.

There is a lesson here, albeit at the tragic expense of the health of newborns. Physicians acted promptly to advise their colleagues. And other physicians listened. So the FDA's action was at worst a monumental goof and at best a poorly managed action of the bureaucracy.

We maintain that these matters are best left in the competent, experienced hands of the medical profession whose sole concern is the preservation and improvement of the quality of life.

From the March 1972 issue, *Journal of the Indiana Medical Association.*

But First, No Harm!

An Australian practitioner* has reported that Worcestershire sauce can precipitate kidney stones which, if not removed, may lead eventually to renal failure. Well, it appears that one of the major functions of this sauce is to cure hangovers. It is, of course, also used as a food condiment. Actually, Worcestershire sauce is what the dictionaries call a "piquant mixture of herbs, spices, soy, and vinegar." Just why this should clear up the hangover is not known, but thousands of revellers swear by it. But the reports from down-under do suggest that glomerular kidney damage with aminoacids in the urine, not to mention albuminuria, hypertension, and nephrolithiasis may result from getting too much sauce. All of this gloomy report is not to suggest that this *Journal* has any expertise in the toxicology of Worcestershire sauce, but rather to underline the old medical aphorism that the first duty of the physician is to do no harm. In this example, the hangover would appear to be a lesser hang-up than the kidney stones.

*Dr. Kevin J. Murphy of the Princess Alexandra Hospital in Queensland (Brisbane) Australia.

ORIGINAL ARTICLES

This careful survey suggests that we do not have too much to boast about in emergency hospital care in New Jersey.

Survey of Emergency Departments in New Jersey Hospitals

Jack R. Karel, M.D., et al./Hillside*

The Medical Society of New Jersey in cooperation with the Division of Emergency Health Services, USPHS, Region II, has conducted the first of a five-part action progr. m to determine the status of emergency departments of all hospitals in New Jersey. Purpose of these exercises is to evaluate and stimulate emergency departments so that they are able to function effectively at all times regardless of the injury or illness. This five-part program includes the following areas: communications, transportation-community organization, manpower staffing, training, and facilities-resources in emergency departments.

To obtain adequate information to evaluate the status of the emergency departments, a series of 44 pertinent questions** were submitted to administrators of hospitals. Results were received from 114 of 141 hospitals.

The survey was conducted by mail rather than personal interview. We realize the scientific limitations of this type of survey and we accept those objections. However, from the information received certain trends become evident and generalizations can be made on that basis.

Type of Hospital

Most of the hospitals answering the questionnaire were private or community nonprofit general hospitals. A lesser number of replies were received from church-sponsored and special-service hospitals. Eighty-four per cent of all the hospitals reported having an emergency room and/or department.

Organization and Administration of the Emergency Department

The number of hospitals with physicians staffing on a 24-hour basis is astoundingly few (i.e., hospitals with full-time emergency physicians on duty). Slightly more than half of the hospitals have either registered or licensed practical nurses on a 24-hour basis. A significant number of hospitals, however, are utilizing non-physician staff personnel who are on call from other departments within the hospital. Only about half of the hospitals have clerical personnel to assist with administrative procedures and patient flow. It was determined that 50 per cent of all hospitals responding have emergency departments which are under the direction of medical advisory committees.

Less than half of the emergency departments have sufficient equipment and supplies properly to treat emergency patients. This includes such equipment and supplies as inhalation devices, cardiac equipment, and poison control carts.

*Dr. Karel is Chairman of the MSNJ Committee on Emergency Medical Care. Coauthors are Louis J. Donofrio, Region II Program Director, and Frederick B. Little, State Program Representative, Division of Emergency Health Services, USPHS.

**Hospital questionnaire may be obtained from Dr. Karel.

Seventy per cent of the hospitals lack radio communication between each other. Ninety per cent of all the hospitals in New Jersey cannot communicate by radio with ambulances.†

Although the majority of hospitals reported having an emergency department, only about half of the total number could function adequately if sufficient, trained medical personnel were available. The majority of hospitals continue to utilize the emergency department as an outpatient and clinic facility.

Discussion

New Jersey is the seventh largest and most densely populated state in the nation, the most highly urbanized and the sixth wealthiest. At least 60 per cent of the population lives north of New Brunswick. Statistics show over the past ten years that the emergency department is the entry point to the health care delivery system. The growth in the use of hospital emergency departments is directly related to specific identifiable problems, such as the growth of medical specialization and decline in the supply of general practitioners, the shortage of physicians in many areas of specialization, the reluctance of physicians to make house calls, the movement of large numbers of people from one area to another, the increase in population, and the use of the hospital as the preferred treatment site for trauma and non-acute illnesses.

Conclusions

The findings of this survey hint at marked deficiencies in many aspects of the field of emergency medical care. Emergency departments have not been given their proper status in relationship with other departments of hospitals. There is a tremendous gap with respect to communication between hospitals, between hospitals and ambulances, and with other agencies.

The emergency department should be separate and distinct from the outpatient department. Proper equipment and trained personnel must be provided to minimize transfer of patients.

The general public and mass media must be educated as to capabilities of emergency departments in the state. Emergency medical care must be placed in its proper perspective and receive the priority status that has been afforded education, ecology, transportation, and the urban crisis.

†Information compiled December 1970.

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This seems to be the first documented case of three separate primary carcinomata of the breast in the same patient.

The Multicentric Origin of Breast Cancer

A Case Report of Three Separate Primary Breast Carcinomas in a Single Patient

Donald K. Brief, M.D., *et al.*/Newark*

Multicentric origin of carcinoma of the breast was first alluded to by Nisbet in 1800 and since that time has been noted frequently in several large series.[1] Davis,[2] in 1920, reported eight cases of bilateral carcinoma of the breast in a series of 166 patients. Kilgore,[3] in 1921, suggested that patients with stage 1 carcinoma of the breast may well have a higher incidence of carcinoma in the second breast should they live long enough to develop a second cancer. Since these two early reports, others have recognized the increased incidence of carcinoma in the opposite breast. It is now generally well established that a patient with primary carcinoma of one breast will be prone to develop another primary carcinoma of the other breast.

It is estimated that about 65,000 new carcinomas of the breast will be diagnosed in this country in the next year and at least 6,000 of them will develop carcinoma in the opposite breast. Insofar as we can tell from a review of the literature there has never been a documented case reported of three separate carcinomas of the breast in a single patient. We have recently treated a patient at the Newark Beth Israel Medical Center who appears to satisfy the criteria for making a diagnosis of three separate carcinomas of the breast and this may be the first reported in the English literature.

A 63-year-old woman was admitted to the Newark Beth Israel Medical Center in September 1969 with a small lump in the region of a previous simple mastectomy scar at its medial inferior aspect, in the region where the major portion of the breast had been before mastectomy. In 1937 a benign tumor, presumably fibrocystic disease, was removed from her right breast. In August of 1952, at age 46, she developed a mass in her left breast and underwent a simple mastectomy. Histologic study revealed this to be an adenocarcinoma (Figures 1 through 5) and

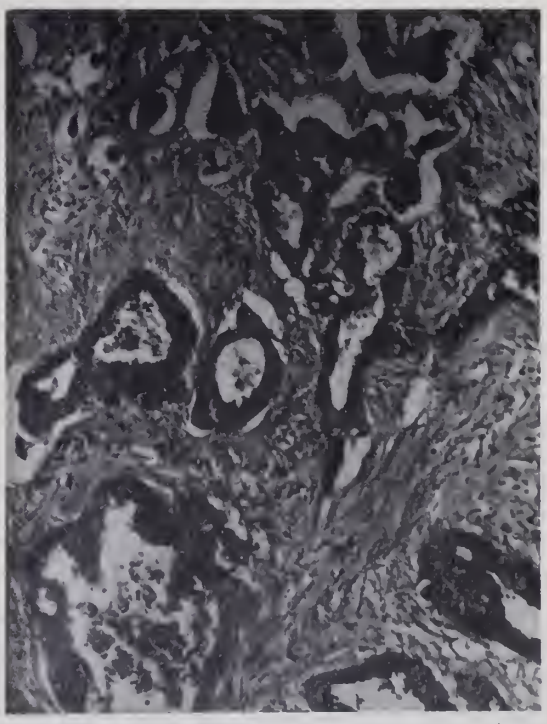


Figure 1—August 1952 (age 46) Left breast—Adenocarcinoma in 1952 low power x 100.

*From the Department of Surgery, Newark Beth Israel Medical Center, Newark, New Jersey, and the New Jersey Medical School, CMDNJ. Coauthors are A. Gopalakrishnan, M.D. and Young M. Kim, M.D.

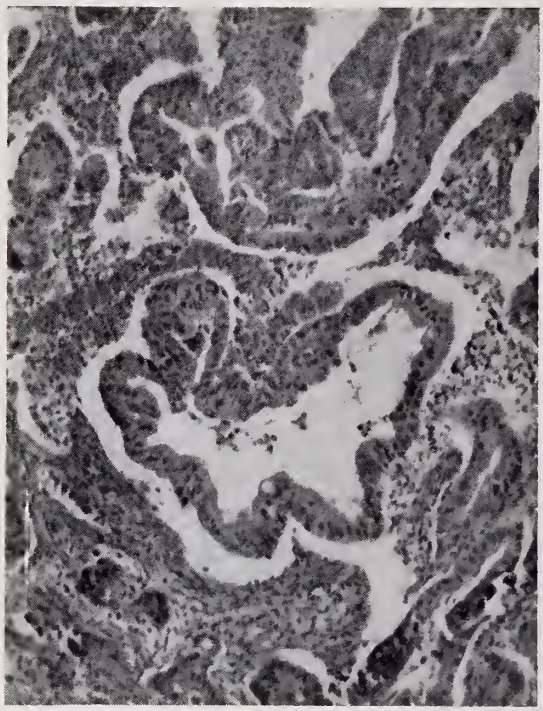


Figure 2—August 1952 (age 46) Left breast—Adenocarcinoma in 1952 high dry x 400.

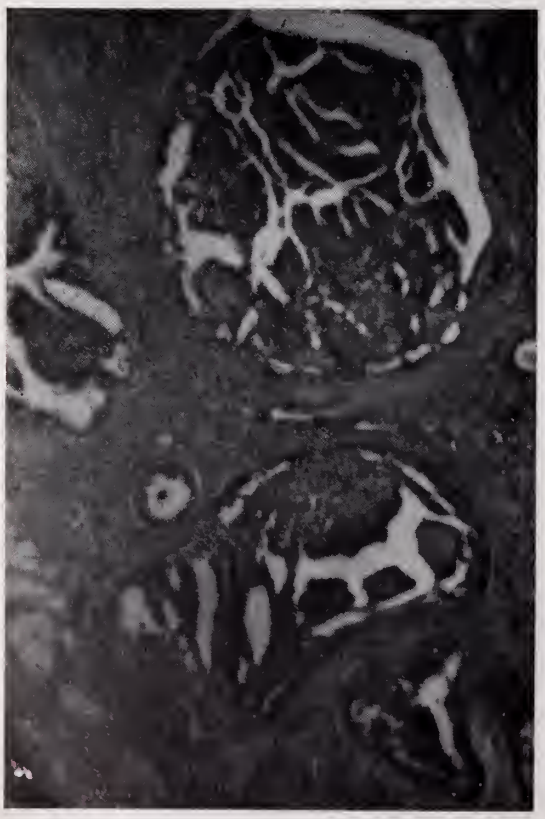


Figure 3—September 1952 (age 46) Right breast showing lobular carcinoma (H & E x 100).



Figure 4—September 1952 Right breast showing lobular carcinoma with areas of *in situ* pattern (intraductal proliferation) x 400.



Figure 5—High power view of Figure 3 showing two types of cell populations. Lobular carcinoma x 400.

she was treated with x-ray therapy postoperatively. No axillary dissection was done at this time. At the time of admission for her first mastectomy on the left side, in August 1952, a small mass was noted in the right breast. One month after her first operation she underwent a simple mastectomy of the right breast. The pathologist found this to be a lobular carcinoma with two different cell types being noted and with no evidence of metastasis. (Figures 3 and 5). These were thought to represent simultaneous separate primaries in both breasts. No x-ray therapy was administered to the right axilla.

Six years later, in 1958, she developed a few palpable

lymph nodes in the left axilla, these were excised and showed reactive hyperplasia without evidence of metastasis. She did well to the present time when she noted the development of a single mass in the previously described location. The mass was firm, two centimeters across, irregular, with retraction of the overlying skin but freely movable from the chest wall. There were no obvious axillary nodes palpable on the right. Skeletal survey and bone scan and liver function studies showed no evidence of metastasis. It was felt at this time that this was either a metastasis from one of her previous breast carcinomas or that it represented a third primary in remaining breast tissue left behind after the simple mastectomy in 1952. In reviewing the operative notes of the operating surgeon in 1952 it was difficult to tell whether a thorough simple mastectomy had been done. During the present admission, a small incisional biopsy was performed on the mass. A frozen section revealed this to be a ductal carcinoma. Consequently, a wide excision of the primary tumor with an incontinuity radical axillary dissection was performed. A skin graft was necessary to close the defect since no excess skin was present because of the previous mastectomy. Postoperatively, the patient recovered well and pathologic report on the specimen showed this to be a ductal carcinoma with areas of scirrhous reaction and foci of *in situ* pattern confirming the fact that this was a third primary carcinoma. (Figures 6 through 9.) Forty-two lymph nodes were dissected in the specimen and sections showed no evidence of metastasis.

A short review of the literature follows with an attempt to answer three major questions: (1) What are the criteria for diagnosing bilateral primary breast carcinoma? (2) What

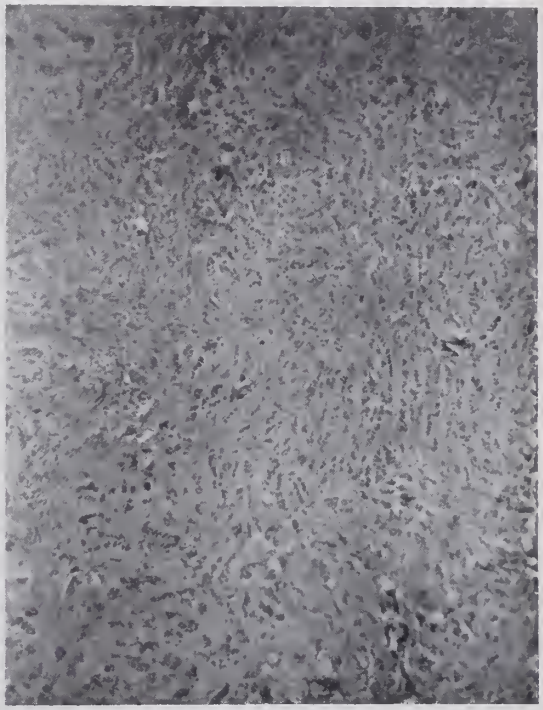


Figure 7—Duct carcinoma of right breast in 1969 (shown in Figure 6) showing areas of scirrhous patterns. (H & E x 40).

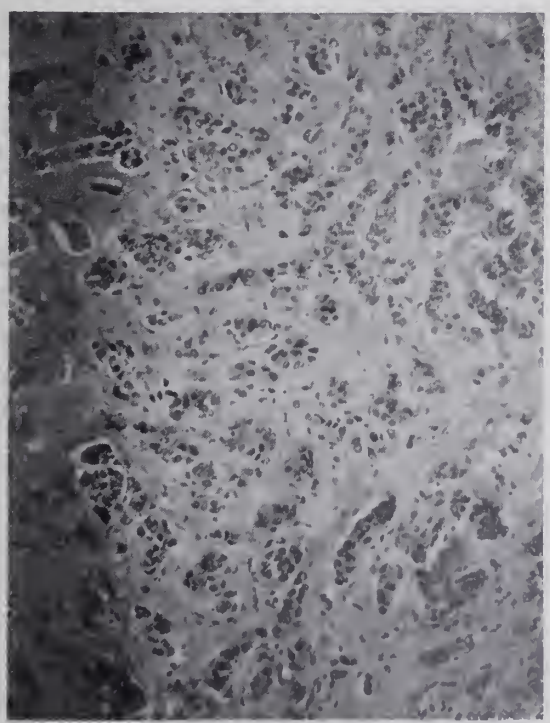


Figure 6—Duct carcinoma of right breast 17 years after simple mastectomy for lobular carcinoma of the same breast.

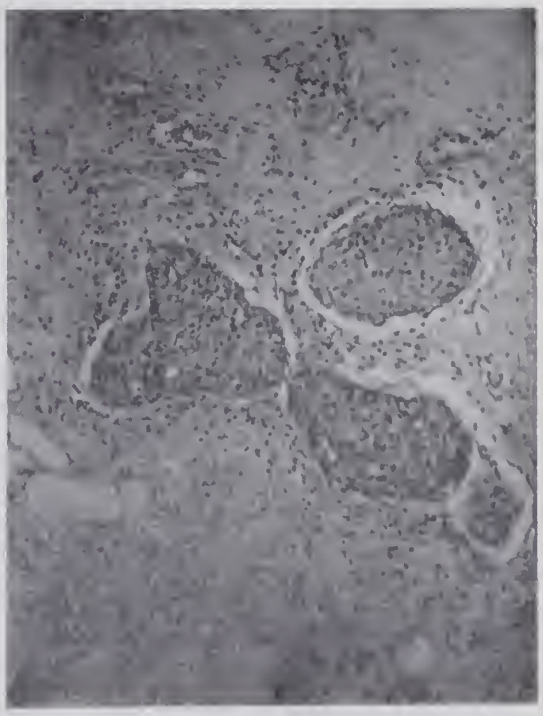


Figure 8—New primary duct carcinoma of right breast in 1969 showing areas of carcinoma *in situ* pattern which confirms that this lesion is a true new primary lesion. (H & E x 40).

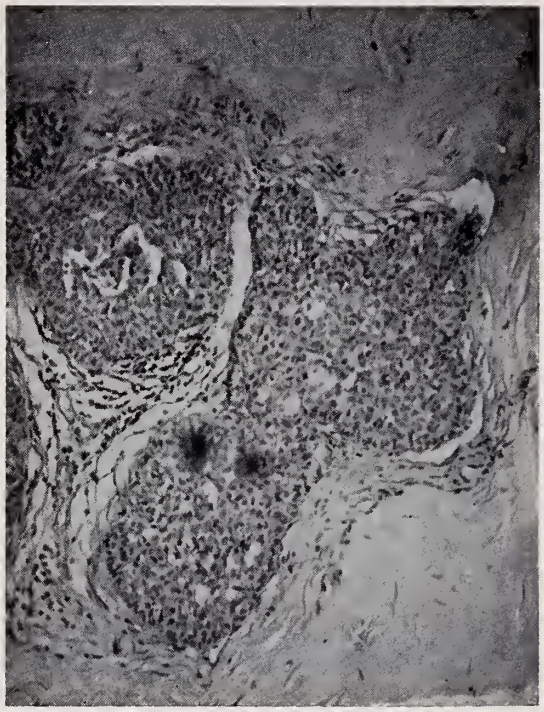


Figure 9—Higher power view of Figure 8 showing a clearer picture of carcinoma *in situ* with foci of calcification. (H & E x 100).

is the incidence of bilateral breast carcinoma? (3) What are the clinicopathological characteristics of the second primary carcinoma?

Criteria for Diagnosing the Second Breast Carcinoma

"Attempts at the recognition and identification of multiple new growths have been made as early as 1869 when Pennel and Kapsinow credited Bilroth for the earliest establishment of criteria of multiplicity." (Quoted from Carroll & Shields)[4] Since then several authors have described the characteristics of the second new primary and in 1954 Guiss[5] reported his criteria which have generally been accepted. Until that time the histo-pathologic difference between the carcinomas was the key to differentiate between á metastasis and separate breast primary carcinoma. The criteria which Guiss described were:

(a) Definite evidence of carcinoma in the first breast being operated upon.

(b) Approximate time interval greater than two years after surgery during which time there was no evidence of recurrence or metastatic disease.

(c) The development of a clinically independent second primary in another breast without evidence of metastasis developing elsewhere.

(d) The clinical course of the patient after the breast operations.

Further characteristics were laid down by Robbins and Berg[6] in 1964 who published an exhaustive study on the clinicopathologic manifestations of second primary breast carcinoma. Their criteria are as follows: (Table I)

TABLE I

Criteria for Distinguishing Primary from Metastatic Breast Cancer

	Primary	Metastatic
1. Site	Breast Parenchyma Upper outer Quadrant	Fat surrounding the breast. Fatty tail of breast, or nearest to mid-line
2. Number	Single	Multiple (satellite nodule)
3. Type of growth	Stellate, crablike	Expansile growth
4. Association with *in situ* ca.	Always present except medullary ca.	Not associated
Histopathological disparity	Different type Degree of nuclear differentiation in same type	
Time limit	5 yrs. (Leis)[9] 2 yrs. (Guiss)[5] 6 mos. (Shilleto)[13]	

(1) *Location:* Breast metastasis from one breast to another is largely lymphatic and so appears most often in the fat that surrounds the breast parenchyma proper rather than in the breast tissue itself. It usually appears in the part of the breast nearest to the mid-line, or when there is a retrogressive spread from nodes in the opposite axilla to the tail of the breast. Second primary breast carcinoma, by contrast, can be expected to be in the breast tissue itself and like the first is usually in the outer quadrant and not in the fatty wall.

(2) *Multiplicity:* Metastases are often multiple, whereas the primary is a single lesion.

(3) *The presence of associated in situ carcinoma:* This is most important because almost any primary breast carcinoma when examined carefully can be found developing in areas in what appear to be *in situ* carcinoma. (Our case Figures 4, 8, and 9) This is not the

case with metastatic carcinoma of the breast in which no such *in situ* appearing lesions can be found. The exception to this is in medullary carcinoma around which *in situ* changes are not expected.

(4) *The type of growth:* In addition, a second primary breast carcinoma was assumed to exist when the first and second cancers disclosed a wide disparity of the histologic type, such as in the case presented herein. It would be most unusual if one found a papillary carcinoma of the breast in one side and medullary carcinoma of the breast in another, and these proved to be metastatic rather than two separate primaries. When the histologic patterns were similar the lesions were considered to be independent primary lesions, if either of the following criteria were present:

(a) The degree of nuclear differentiation of the second was definitely greater than the first lesion.

(b) The second lesion appeared more than five years after the first lesion, when the patient was without any evidence of metastatic disease at the time of detection of the second lesion.

(5) *Incidence of multiple carcinomas of the breast:* Malignant tumors of the breast may have multicentric origins as do lesions of skin, oral mucosa, colon, ovary, cartilage, and peripheral nerve sheath. The same phenomenon also appears in the breast. Thus Cheatle,[7] in his original research, reported on the occurrence of multiple foci of breast carcinoma while Qualheim and Gall[8] in a study of sections of 157 breasts removed for carcinoma found multiple foci of carcinoma in 54 per cent of specimens. They concluded that primary mammary carcinoma (as carcinoma does in other areas) constitutes a disorder of the entire organ and appears to be a multicentric process. It is not surprising that breast carcinoma should occur bilaterally since the breast is a paired organ and should be considered as an anatomic system rather than as separate unrelated organs. Both breasts are under the same genetic and hormonal influence. The literature indicates that bilateral breast carcinoma occurs in 1 to 20 per cent of breast carcinoma patients. Such a variation reflects factors as duration of survival after the first carcinoma, rigidity of diagnostic criteria, the age of patients, and so on. Simultaneous bilateral primary breast carcinomas are uncommon and occur in a range of 0.1 to 2 per cent whereas a non-simultaneous bilateral primary breast carcinoma is fairly common occurring in an average of 8 per cent of patients with breast carcinoma. The variability of these figures is shown in Table II and Table III.

TABLE II

*Simultaneous Bilateral Primary Breast * Carcinoma Incidence*

Authors	*Per cent*
Guiss	0.1
Ruef and Ehlers	0.2
Hartnett	0.3
Moertel and Soule	0.3
Robbins and Berg	0.3
Leis	0.3
Herrmann	0.4
Farrow	0.4
Haagensen	0.4
Mithers, *et al.*	0.6
Greenough	0.7
Desaive	0.7
Mustacchi, Pandolfi, and Bucalossi	0.7
Harrington	1.0
Trushnikova	1.0
Hubbard	1.09
Caroll and Shields	1.4
Lewis and Reihoff	1.5
Berard and Ballivet	1.5
Clifton and Young	1.5
Fits and Patterson	1.8
Kountz, Bell, and Ahlquist	2.0

* Quoted from Leis, *et al.*[9]

TABLE III

*Non Simultaneous Bilateral Primary Breast * Carcinoma Incidence*

Authors	*Per cent*
Guiss	1.0
Sartori	1.0
Kilgore	1.1
Herrmann	1.5
Greenough	1.6
Berard and Ballivet	1.6
Moore, Judd, and Moore	1.7
Haagensen	1.9
Mustacchi, Pandolfi, and Bucalossi	2.2
Smithers, *et al.*	2.4
Reese	3.0
Farrow	3.2
Caroll and Shields	3.3
Lewis and Rienhoff	3.3
Hartnett	3.4
Desaive	3.6
Moertel and Soule	3.7
Treves and Holleb	4.2
McWilliams	4.7
Fits and Paterson	5.7
Robins and Berg	6.5
Leis	7.6
Keyes, Jordan, and Wyatt	12.0

* Quoted from Leis, *et al.*[9]

(6) *Clinicopathological features of the second carcinoma:* The literature suggests that second breast carcinoma develops more frequently in patients who are less than 50 years of age at the time of the initial carcinoma and in those patients with a high family incidence of breast carcinoma. Women who are younger than 50 at the time of the first breast carcinoma have twice the yearly risk of developing carcinoma in the second breast as against those who are more than 60 years old. In the series of Robbins and Berg,[6] the maximum number of second primary carcinomas of the breast appeared in the immediate years following the initial surgery. Of particular interest was the finding that the risk of developing a second primary breast carcinoma was greater in those patients whose initial lesions were of the type associated with a better than average prognosis as in lobular, *in situ* carcinomas, comedo carcinomas, the colloid, medullary types, and the stage I cases in general. Recently, it has been reported by Patrick[9] that the occurrence of pregnancy after the removal of one breast for carcinoma seems to favor the occurrence of carcinoma in the other breast. This has not been well documented.

Survival rate after a second breast carcinoma is poorer than that of the first carcinoma alone. Moertel and Soule[10] reported a 56 per cent five year survival rate after the second carcinomas as compared to 60 per cent after the first. Robbins and Berg[6] have a five year survival rate of 54 per cent after the second and 62 per cent after the first carcinoma. The figure of 70 per cent survival after the second was reported by Clifton and Young.[11] Harrington[12] reported an over-all of 15 year survival rate of 25 per cent after the first carcinoma and 19 per cent 15 year survival after the second carcinoma. From the composite it would appear that the second breast carcinoma is a substantial additional risk to the patient since only about 50 per cent of patients with a second primary survive five years after the removal of the breast.

These results are summarized in Table IV.

TABLE IV

Prognosis in Bilateral Breast Cancers

Authors	5 year Survival After First Ca.	5 year Survival After Second Ca.
Moertel and Soule	60%	56%
Robins and Berg	62%	54%
Clifton and Young		62%
Harrington	25% *	19% *
Leis		97.8% 48.9% after 10 years
McWilliams		38.0%
Mersheimer		97.2%

* 15 year survival figures.

Comment

When one sees a patient with two breast tumors it is difficult to tell whether these are two different primary carcinomas or metastatic disease from one breast to the other. According to Shilitto,[13] metastasis from one breast to another appears most often in the fat that surrounds the breast parenchyma proper, or is, also often, either in the part nearest the mid-line or in the tail of the breast from retrogressive spread from the axillary lymph nodes. The second primary breast carcinoma can be expected to be in the breast tissue. In our patient, all three tumors were in breast tissue parenchyma, and had histologic characteristics of separate tumors. Metastases tend to be multiple, especially on microscopic examination. They tend to grow in an expansile fashion rather than the more common stellate, crablike growth patterns of primary disease. Most important, metastases are not associated with continuous *in situ* carcinomas while such *in situ* foci are the rule in primary carcinomas. The long free interval without evidence of any metastatic disease occurring again suggested that this is a third primary. It seems obvious that in the performance of a simple mastectomy, all breast tissue should be removed. In this particular case residual breast tissue was left behind on the right and a third primary obviously developed.

Recently a subcutaneous mastectomy with replacement of silicone prosthesis has been reported in the treatment and management of severe chronic fibrocystic disease or adenosclerosis with multiple biopsies being necessary. Should the surgeon perform this procedure with anticipated plastic repair it is required that he carry out a thorough mastectomy. Obviously the remaining breast tissue may be the source of difficulty and diagnostic confusion in the future.

Summary

A 63-year old woman was treated for three histologically distinct and separate primary breast carcinomas. The third tumor was discovered in residual breast tissue following a right simple mastectomy for lobular carcinoma seventeen years previously and was treated by radical mastectomy. Pathology showed this tumor to be ductal carcinoma arising in residual breast tissue. The histology of the left breast tumor was adenocarcinoma treated by simple mastectomy in 1952. There were no positive nodes in any of the specimens including the radically resected right breast ductal tumor.

This case satisfies all of the criteria outlined by previous authors differentiating separate and distinct breast cancers from metastatic breast cancers in the contralateral breast, and is the first such case to be reported.

If simple mastectomy is performed for any reason care must be taken to remove all breast tissue.

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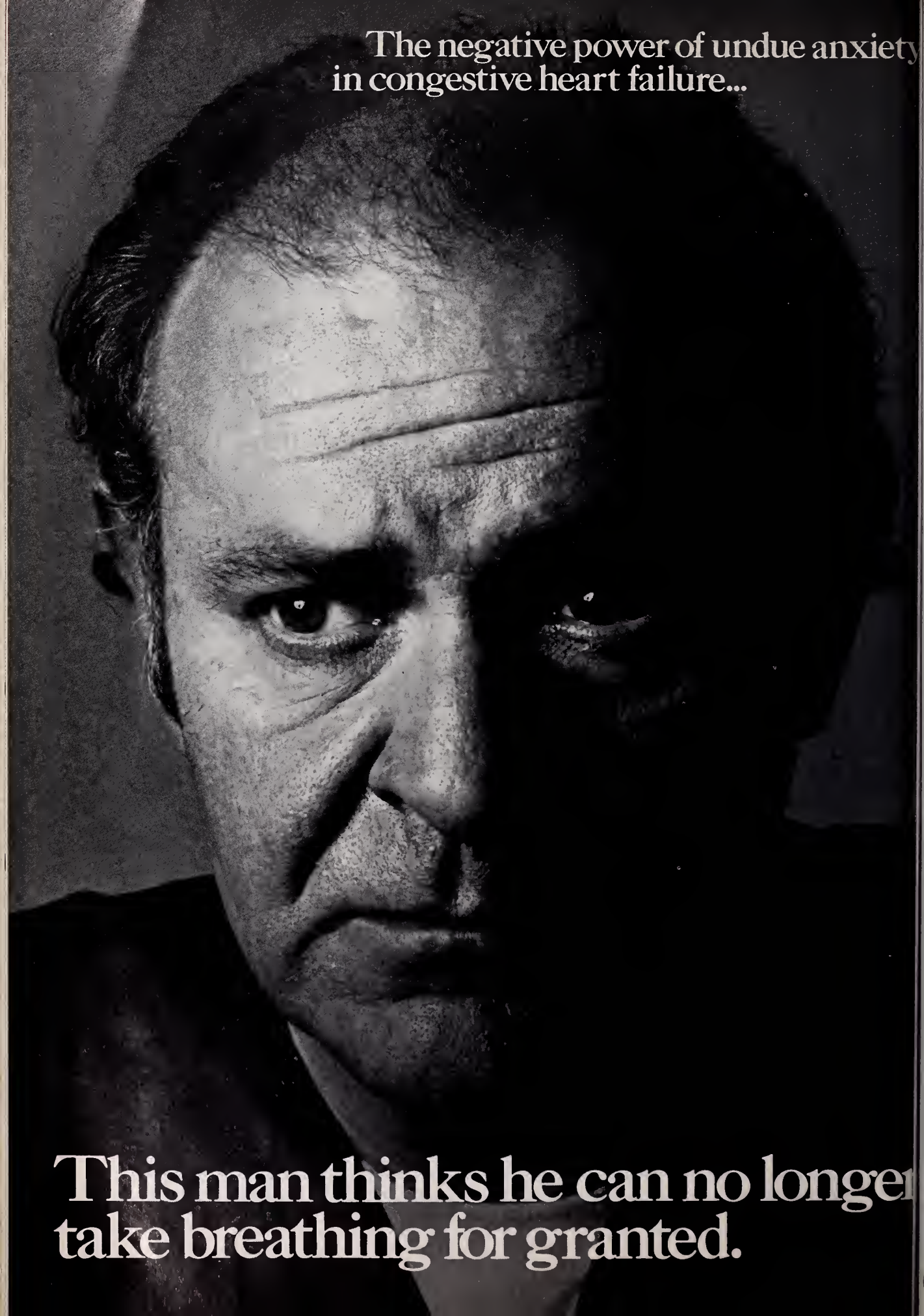
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Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

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Dear Doctor:

Arbitrary and short-sighted rulings of third party insurance carriers appear to be directly and indirectly hampering your prerogative in ordering laboratory tests. We, therefore, want to bring to your attention pertinent quotes from a recent report, encouraged by Congress, by a section of the National Institute of Health which evaluates the relationship between the physician and the clinical laboratory, for now and the future:

> "The excellence of future medical practice will depend to a large degree on the development of new and improved laboratory measurement. . . . By correlating these data with clinical information, physicians can make the best diagnosis or evaluate therapy for their patients with the least delay."(1)

The use and acceptance of the concept of using multiple analysis and determining related parameters to aid in your diagnosis and treatment is both praised and affirmed in this report by the following quotes:

> ". . . the severity of the disorder in clinical terms may not be directly related to the degree of divergence from the "normal" for the biochemical parameter under study."(1)

> ". . . that frequent measurements of the same parameter on different occasions or many related parameters at the same time may be more valuable than the static measurement of a single parameter."(1)

Apparently then, multiple analysis is currently considered a necessary tool to be used by the physician in diagnosis and therapy. Recent insurance rider restrictions and administrative harassments tend to restrict your free choice of these tests. But the carrier does not assume your responsibility and liability for the well being of your patients. You have the ultimate authority and you bear the final responsibility for the management of your patients.

We are writing this letter because we perform laboratory testing. We are proud of the advances in the services which we have brought to the people we serve. We wish to continue to bring advances in quality, techniques, and services to a full spectrum of laboratory determinations for you to use as aids in diagnosis.

If third parties dictate what test can be ordered, everyone will suffer—you, your patients and us.

Respectfully,

Bernard C. Kaplan
President

(1) A Status Report of the National Institute of General Medical Sciences, National Institute of Health, "The Mechanization, Automation and Effectiveness of the Clinical Laboratory," 1971 DHEW (NIH) 72-145 pp. 1-7.

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Increasing use of antibiotics has made many of us less interested in the blood culture. Here is a well-rounded report of the implications of over 1600 blood cultures.

Clinical Significance of Positive Blood Cultures*

Stanley Burrows, M.D. and Dorothy Gottesman, B.A./Camden

The circulating blood is normally sterile. Blood cultures are frequently performed in the study of febrile episodes of obscure nature or that suggest dissemination of a previously localized infection. However, not all positive blood cultures are clinically significant and a reasonable proportion may represent contamination of cultures by nonpathogenic microorganisms. During 1970, 1662 blood cultures were performed at The Cooper Hospital. The records of all of the patients with positive blood cultures were reviewed to determine the clinical significance of various bacteria in the blood. Experience may vary from year to year or among different hospitals, but analysis of this experience in a large general hospital may serve as a basis for the clinical interpretation of positive blood cultures.

Using sterile technic, approximately 5 cc. of blood are drawn directly into each of two blood culture bottles containing 50 cc. of broth: tryptic soy broth and thiol broth (Difco Laboratories, Detroit, Michigan). Each blood culture bottle contains sodium polyanetholsulfonate to inactivate normal antibacterial factors in blood and carbon dioxide to promote growth of the more fastidious organisms. The tryptic soy broth is cultured under aerobic conditions, whereas anaerobic conditions are maintained for the thiol broth.

Culture bottles are incubated until growth is seen or for at least seven days. Smears and subcultures are routinely made after 24 hours for detection and identification of bacteria and, if negative, again when the broth is suspicious for growth or after seven days of incubation.

Results

Results of blood cultures with listing of organisms isolated are shown in Tables 1 and 2. Although the incidence of positive cultures of 8.6 per cent was less than 13 per cent of a

Table 1

Incidence of Positive Blood Cultures

Total blood cultures		1662	
Positive cultures		143	(8.6%)
Pure cultures	136		
Mixed cultures	7		

Table 2

Organisms Isolated (150 isolates)

Staphylococcus aureus	15
Staphylococcus epidermidis	14
Streptococcus	12
Diphtheroids	15
Pneumococcus	9
Escherichia coli	27
Enterobacter	13
Proteus	11
Pseudomonas	9
Bacteroides	6
Hemophilus influenzae	4
Clostridium perfringens	3
Neisseria meningococcus	2
Salmonella enteritidis	2
Bacillus subtilis	2
Serratia	2
Listeria monocytogenes	1
Mima polymorpha	1
Hafnia	1
Gaffkya tetragenes	1

*From The Cooper Hospital in Camden, where Dr. Burrows is chief attending pathologist and Mrs. Gottesman is bacteriologist.

large series reported by Kotin[1], this can be largely attributed to a lower incidence of nonpathogenic Staphylococcus epidermidis in our series (10 vs. 38 per cent). Most of the blood cultures at Cooper Hospital are drawn by a small group of specially trained bacteriology technicians. This has reduced the incidence of isolations of nonpathogenic contaminants in blood cultures.

Analysis of Results

Microorganisms that did not appear to be clinically significant in blood cultures included Staphylococcus epidermidis, Diphtheroids of Corynebacterium species, Serratia, Bacillus subtilis, Hafnia, Mima polymorpha, and Gaffkya tetragenes. This does not refute their significance in special situations, but none of the isolations at Cooper Hospital could be correlated with clinical infection. Especially for Staphylococcus epidermidis, that is a common nonpathogenic skin contaminant, repeated isolations from the blood are necessary before considered clinically significant.[2]

Staphylococcus aureus: The isolations from nine of the twelve patients were considered clinically significant, including three with acute bacterial endocarditis, two children with acute Staphylococcal osteomyelitis, two with septicemia probably originating from venous catheters, and two with probable Staphylococcal pneumonia and septicemia. Two of the remaining three patients had fever and possible pneumonia, but died without clarification of the disease process. Staphylococcus aureus in blood cultures is usually of clinical significance and may originate from intravenous catheters in the absence of other sources of infection.

Streptococcus: The three isolations of beta hemolytic Streptococci were all in newborns. Only the one from an infant with clinical meningitis with culture of Streptococcus (group B) from both spinal fluid and blood was considered significant. One isolation was from an afebrile newborn requiring exchange transfusion for ABO hemolytic disease and an isolation of group D Streptococcus was from a premature infant with a mild aspiration pneumonitis that rapidly cleared.

One isolation of enterococcus was considered the causative agent of subacute bacterial endocarditis in a 58-year old man. The three other isolations, including two newborns, were not clinically significant. Isolations of anaerobic and microaerophilic Streptococci were also not clinically significant. Isolations of Streptococci from the blood did not appear to have clinical significance unless correlated with endocarditis, an association that occurred only once during the year.

Pneumococcus: Six of the nine isolates were from five patients with pneumonia, and one was from a 10-year old boy with nephrosis and anasarca and probably pneumococcal septicemia. The other two cultures were of doubtful significance, one from a newborn with respiratory distress syndrome and the other, from an 8-month old infant with Staphylococcal otitis media. Blood cultures are probably of greater value than sputum cultures in the diagnosis of pneumococcal pneumonia because they are more often positive and pneumococci may be cultured from the nasopharynx of 35 to 60 per cent of normal persons.[3]

Escherichia coli: Twelve isolations were from seven patients with urinary tract infection and clinical bacteremia. Six were from three patients with choledocholithiasis and fever, with another isolation from one patient with fever after cholecystectomy and closure of a fistula between the common bile duct and the duodenum. Other patients with clinical bacteremia included a 75-year old man with acute peritonitis from ruptured colonic diverticulitis, a 52-year old female alcoholic with delirium tremens who died after development of high fever, a 32-year old male cirrhotic with pneumonia, and two newborn infants. The isolations were of questionable significance in a 54-year old male alcoholic who died with fever within 24 hours of admission and two newborn infants with transient fever or poor respiration. E. coli bacteremia appears most likely to occur in patients with

urinary tract or biliary tract disease, fecal peritonitis, or the newborn period.

Enterobacter: Bacteremia was clinically evident in eight of the nine patients and the organism was present in pure culture in the one to three blood cultures from each patient. Underlying conditions included urinary tract infection or urologic surgery, biliary obstruction from carcinoma of the pancreas,[1] gunshot wound of abdomen with bile peritonitis, metastatic carcinoma of the sigmoid colon,[1] and fracture of femur. An isolate from a 20-year old woman with chronic active hepatitis and fever, with death in hepatic coma, is of questionable significance. Enterobacter bacteremia appears most likely to develop in older patients with urinary tract or biliary tract disease.

Proteus: Eight isolates were from four patients with urinary tract infection and clinical septicemia with the same organism present in the urine. One patient with similar clinical findings had a mixed infection with Pseudomonas. The isolation was of questionable significance in a 66-year old man who developed transient fever after prostatic resection but had a sterile urine. The isolation of Proteus from the blood is most likely in the presence of urinary tract infection caused by the same organism.

Pseudomonas: Four isolates were from three patients with pyelonephritis or catheter drainage of the bladder, with clinical septicemia and positive urine cultures. Cultures from five other patients were considered clincally significant and were associated with fecal peritonitis due to perforated colonic carcinoma, acute myelogenous leukemia with septicemia, chronic lymphocytic leukemia with septicemia, and with prematurity of two infants who developed fever and sepsis soon after birth. Pseudomonas was always significant in blood cultures, particularly in the presence of urinary tract infection or leukemia.

Bacteroides: Three of the six isolates were from two patients with gunshot perforations of the colon and one patient with perforation of the colon due to vascular insufficiency following resection of an abdominal aneurysm. All of these three patients had clinical septicemia. Another patient who was a diabetic, admitted for inguinal herniorrhaphy, developed a spiking fever during hospitalization with the isolation of Bacteroides in pure culture from his blood with good response to antibiotic therapy. The other two patients had clinical septicemia, probably caused by other organisms, but may have also had true Bacteroides bacteremia, one developing after cholecystectomy and choledochotomy for choledocholithiasis and the other after the development of large decubitus ulcers following a cerebrovascular accident. Bacteroides bacteremia is most likely to occur in old patients with gastrointestinal neoplasms[4] or surgery and its identification in blood cultures may be hampered by its slow growth.[5]

Hemophilus influenzae: All four isolates were from infants of 10 months to 2 years of age with meningitis. The same organism was found in the spinal fluid of three of the four infants, but could not be cultured from the spinal fluid of one infant. Our results indicate that although the diagnosis of Hemophilus influenzae meningitis can usually be made from bacteriologic analysis of spinal fluid, some cases may occur in which the blood culture provides the bacteriologic diagnosis. Blood cultures should be considered in patients with signs of bacteriologic meningitis. The isolation of H. influenzae in blood cultures from patients with pneumonia, especially right-sided lobar or segmental type, should raise a suspicion of H. influenzae pneumonia.[6]

Clostridium perfringens: One isolate was from an 82-year old man who developed a wound infection of a mid-thigh amputation site with foul odor and crepitance and who died with clinical evidence of gas gangrene. Clostridium was not considered the pathogen in an isolation from a 32-year old man with cirrhosis, pneumonia, and clinical septicemia and was present in mixed culture with E. coli, the more likely pathogen. An isolation

from a 44-year old man with Zieve's syndrome† and alcoholic encephalopathy was not considered clinically significant. Clostridia often contaminate the skin, particularly over the lower portion of the body, and cultures yielding Clostridia can be evaluated only in conjunction with clinical findings.

Neisseria meningococcus: One isolate was from a newborn with fever and a macular skin rash, and the other from a 52-year old cirrhotic male with spiking fever. Both were considered cases of meningoccemia and showed good response to antibiotics.

Salmonella enteritidis: One isolate was from a one-year old infant with fever and diarrhea. The same organism was found in his feces. The other isolate was from a 78-year old man with a temperature of 104, without localizing signs. His Salmonella septicemia responded rapidly to chloromycetin.

Listeria monocytogenes: The isolate was from a newborn with respiratory distress and evidence of aspiration pneumonia. The infant was delivered by Cesarian section after the mother developed high fever and evidence of fetal distress. The pathogenic significance is not certain, but strongly suspected. There was rapid clinical response to penicillin therapy.

†Zieve's syndrome refers to a combination of hyperlipidemia, hemolytic process, and often with abdominal pain in patients with cirrhosis. It may masquerade as an attack of acute pancreatitis.

Summary

Although variations may occur among different patient groups, our experience indicates the likelihood of clinical significance in the isolation of gram-negative bacilli such as Pseudomonas, Enterobacter, E. coli, and Proteus. Other organisms usually of clinical significance include Salmonella, Hemophilus influenzae, Neisseria meningococcus, Pneumococcus, Staphylococcus aureus, and Listeria monocytogenes. Organisms less likely to be of clinical significance include Streptococcus, Bacteroides, and Clostridium. Other organisms, such as Diphtheroids, Staphylococcus epidermidis, Serratia, and Mima polymorpha are rarely of clinical significance. However, the proper evaluation of any blood culture can only be done with careful correlation with clinical findings.

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The Cooper Hospital

What to Expect on the Witness Stand

A new film, "Next Witness," depicts to physicians what may be expected if called upon to be a medical witness in personal injury litigation. The film stresses the importance of pretrial preparation for the medical witness. The story line shows how the lack of preparation could create awkward and embarrassing situations in court. This motion picture is of particular value to the medical profession because about 70 per cent of all court action constitutes personal injury litigation, often requiring a physician's testimony.

"Next Witness' is a 16 mm, sound-color film which runs 29 minutes. It was produced by Vision Associates, Inc. Prints are available on loan from the AMA Film Library, 535 North Dearborn Street, Chicago 60610.

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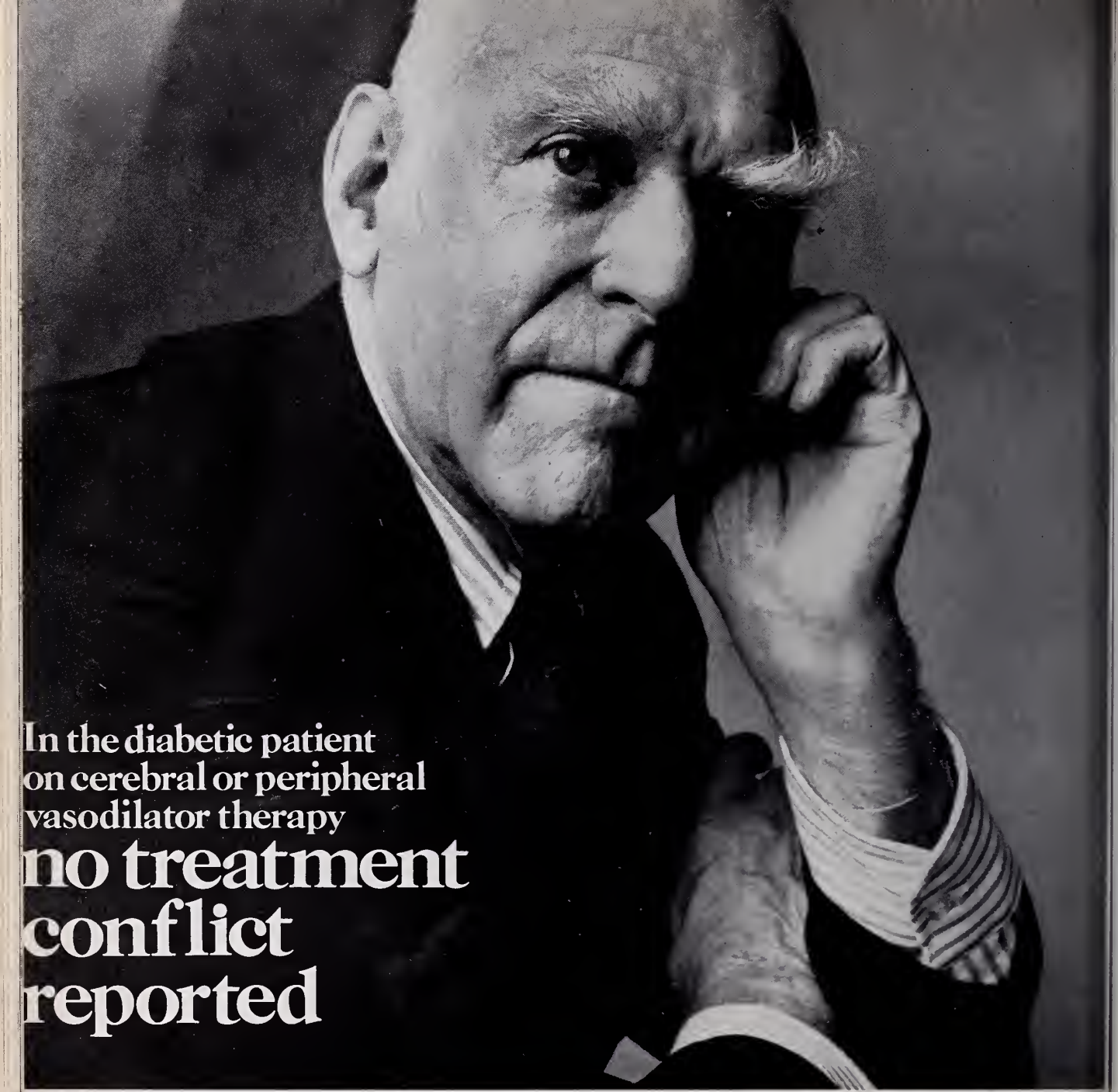
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This country seems to have lagged behind the nations in northern Europe in the use of mediastinoscopy.

Routine Mediastinoscopy in a Community Hospital*

Ralph J. Lewis, M.D. and Philip J. Kunderman, M.D./New Brunswick

Mediastinoscopy is visualization of the mediastinum using a scope. The procedure was first described by Carlens[1] in 1959 and was swiftly accepted and widely used in many European countries. Only recently has it become much utilized in the United States. This tardy acceptance may, perhaps, be attributed to the word *mediastinoscopy* which provokes visions of blind probing amongst the great vessels and vital structures of the mediastinum. Actually, it is a well-controlled, carefully executed, safe, highly rewarding procedure, if it is done by someone experienced in the technic. In a sense it is an extension of scalene node biopsy[2], cervicomediastinal exploration[3], and rib resection.[4] Information previously obtained only by thoracotomy can now be made available by mediastinoscopy.

Reports by Pearson[4], Maasen[5], Reynders[7], and Carlens[1] suggest that mediastinoscopy is important in establishing a diagnosis and determining operability. In many instances it can prevent a needless thoracotomy. When scalene nodes are not palpable, only one in fourteen excisions will result in a positive tissue return. In similar circumstances one in three mediastinoscopies will be positive. In carcinoma of the lung, a lesion can appear to be resectable after scalene node excision, bronchoscopy, laminography, bronchography, pulmonary scanning, and pulmonary angiography. If these same patients were then submitted to mediastinoscopy, one in three would be found to have mediastinal lymph node metastases and would really be unresectable.

In contrast to scalenectomy, mediastinoscopy allows visualization and exploration of both sides of the mediastinum. The contralateral nodes contained tumor in 10 per cent of all positive mediastinoscopies, when the ipsolateral nodes were benign. Thus, one out of ten patients with negative ipsolateral nodes at the time of thoracotomy would have already metastasized to the contralateral nodes. Despite the absence of nodal metastases during exploratory thoracotomy, these patients would have to be considered inoperable.

The national average for resectability of pulmonary neoplasms *without* utilizing mediastinoscopy is about 60 per cent. When mediastinoscopy is used resectability rates approach 90 per cent because of better selectivity of patients.

This procedure has also provided diagnostic information in pneumoconiosis, lymphomas, Hodgkin's disease, and, particularly, sarcoidosis.

The procedure is performed in the operating room. The patient is intubated under general anesthesia. In some instances it has been done under local anesthesia. A 2 to 3 inch transverse, lower cervical incision is made through the skin and subcutaneous tissue. After separating the strap muscles, the pretracheal fascia is entered. Digital exploration of both sides of the trachea (in many instances) will reveal tumor masses. The mediastinoscope is then inserted and biopsies are

* From the combined cardiothoracic services of the Middlesex General Hospital and St. Peter's General Hospital in New Brunswick.

obtained from the middle and posterior mediastinal areas. The skin is closed with #5:0 silk, usually without drainage.

Mediastinoscopy has been performed routinely since 1966 and our experience now includes over 300 cases. This series contains our first 100 consecutive mediastinoscopies from which positive tissue has been obtained in 31 cases. There were four patients with sarcoidosis, four with Hodgkin's disease, one with malignant lymphoma, and 22 cases of carcinoma of the lung. Patients with Hodgkin's disease and malignant lymphoma were certainly spared a major thoracotomy by delineating their disease process by this benign modality.

Positive tissue could not be obtained from four patients with thymoma since the procedure allows safe exploration of the posterior mediastinum only. No attempt has been made to extend the technic and explore the anterior mediastinum where major vessels are situated. Mediastinoscopy did reveal no lymph node metastases in these cases and each patient was successfully resected.

In carcinoma of the lung, 19 patients had no contraindications to surgery and 17 were successfully resected for a resectability rate of 90 per cent. Of 43 patients with bronchogenic carcinoma, positive tissue was obtained by bronchoscopy alone in 10 (23 per cent), mediastinoscopy 22 (51 per cent), and combined bronchoscopy and mediastinoscopy 28 (65 per cent). Mediastinoscopy, therefore, gave a positive tissue diagnosis more than twice as often as bronchoscopy. When combined with bronchoscopy the yield is very rewarding.

In this series there has been no mortality or serious complications. Most patients were ready for discharge 24 to 48 hours after the procedure. Other series have reported a very minimal incidence of hemorrhage, pneumothorax, and injury to the recurrent laryngeal nerve. As yet, we have seen none of these problems.

When mediastinal lymph nodes contain tumors, the lesion is usually unresectable. We feel that a high ipsolateral node, a contralateral node, a fixed mediastinal mass, or an oat cell carcinoma are all contraindications to a thoracotomy.

We are satisfied that mediastinoscopy is a rewarding procedure with low morbidity and mortality. It prevents needless thoracotomies and raises the resectability rate to 90 per cent. Since it permits better selection of patients for resectional surgery, it is hoped that the five year survival rate will also be increased.

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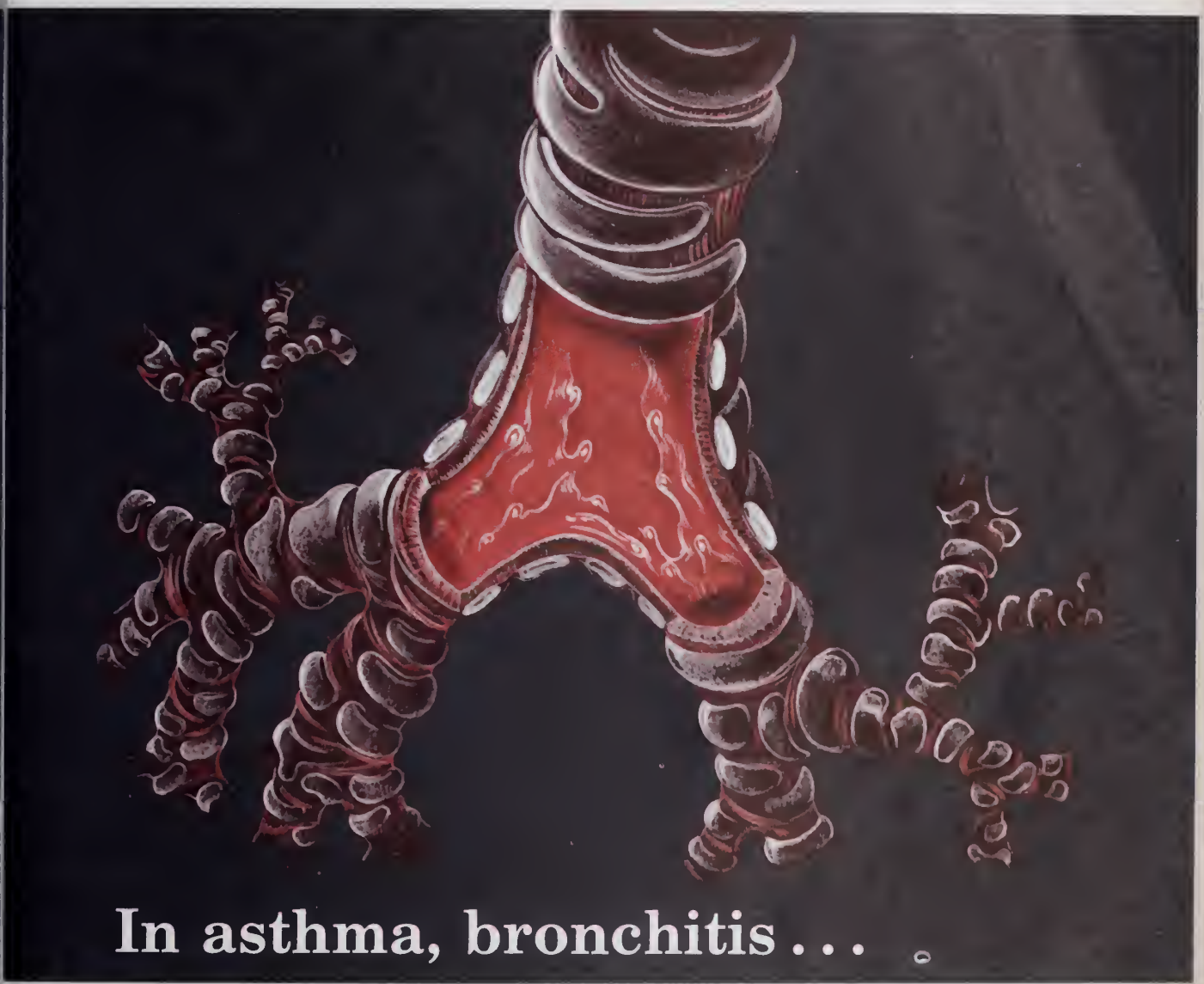
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THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

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References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.



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This report is a project of the New Jersey Allergy Society

Tree Pollination in Northern New Jersey

Michael S. Mattikow, M.D., Kurt Banta, B.S., and Irving Weiss, M.D./Wayne

Pollen counts have become a popular item with the mass media in the last few years. The New Jersey Allergy Society, in cooperation with doctors and hospitals from the state, is attempting to do systematic counts using a standard method. The following report covers tree pollens as counted at Chilton Memorial Hospital, Pompton Plains, New Jersey, in 1971.

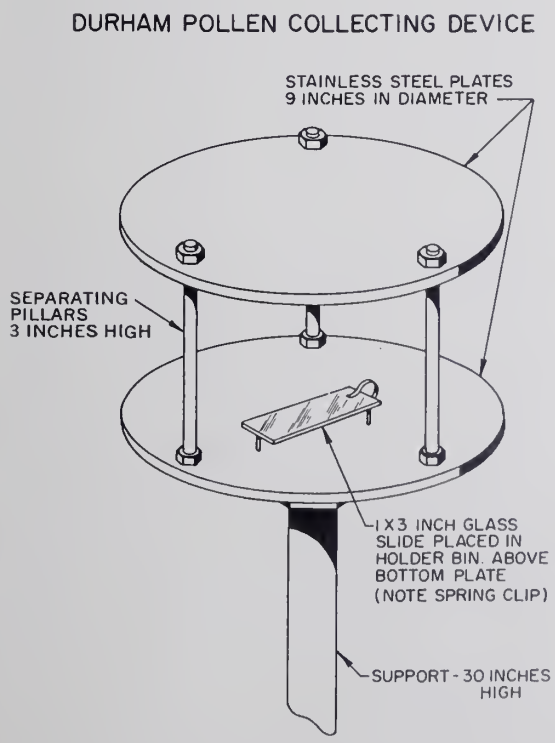


FIGURE 1

A Durham counter, (Figure 1), was placed on the roof of the two story structure (Chilton Hospital) which is in a valley surrounded by wooded hills. The town itself is surburban, with rural areas on its outskirts. The counting was done as described by Durham.[1] Slides were removed every week-day at 8 a.m. and counted immediately. Those placed on Friday were left in place over the weekend and read the next Monday. Since on a dry, windy day within a twenty-four hour period most of the pollen has already been spread by the early hours of the morning, this adequately reflected existing conditions for a given day.[2] However, on damp days, pollen is usually not blown by the wind until later in the day when the air begins to dry, therefore, on such a day a low count would be recorded.

Results

The tree pollination season was spread over approximately eleven weeks beginning in late March and going through early June (Figure 2). This period varies in different years depending on climate. The largest concentration of tree pollen was collected in May (Figure 2), but different families of trees had their peak pollination at different times over the eleven week period (Figure 3).

The alder, for instance, pollinated early, while others such as hickory and mulberry were late. Some trees such as birch and oak gave off pollens throughout the eleven week period, while linden and mulberry had short periods of pollination (Figure 3).

The Durham Counter is a gravity method of pollen counting and heavier particles will be

perferentially counted. Light pollens such as nettles may be missed.

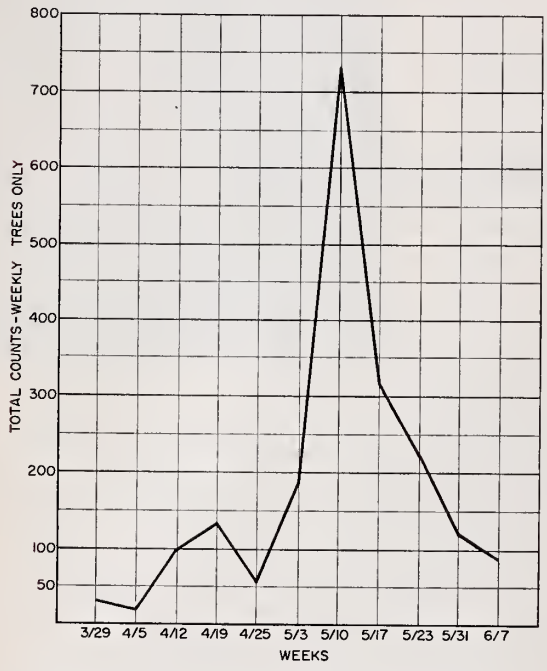


FIGURE 2

Period of time over which pollen of each tree was observed. Vertical line indicates peak.

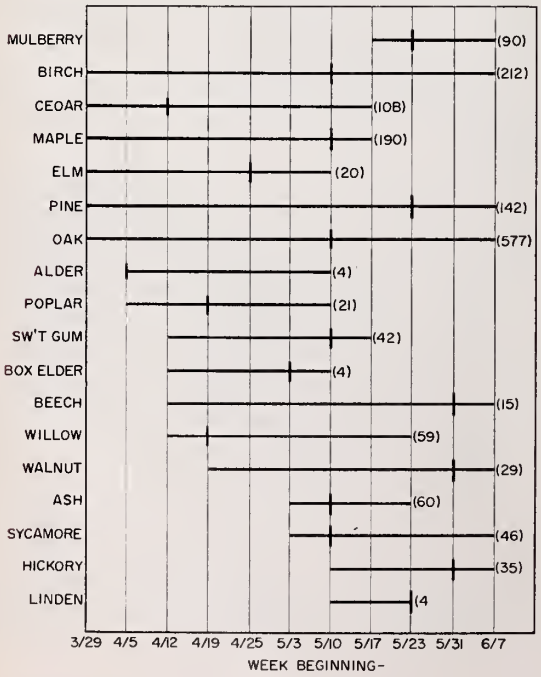


FIGURE 3

Horizontal line represents period pollen observed. Vertical bar is peak period. Number in parenthesis is total pollen count over entire counting period.

Comments

Most textbooks of allergy consider ragweed hayfever as the most important cause of seasonal allergic symptoms in the eastern United States with grass, mold, and trees following in order of frequency.[3] However, it is our impression that in this area of northern New Jersey, trees are second only to ragweed in importance. Hospital studies[4] on asthma admissions show May and November to be the peak months. May corresponds to the peak tree pollination season.

Pollen counts are useful mainly for their qualitative results. Along with simple plant recognition they tell the allergist what plants are present in the area. They also tell when pollination is occurring which is extremely useful in deciding which particular plant is causing symptoms in a particular patient. The actual number of grains collected of each pollen over a season is of less significance since the number would be biased toward the trees closest to the counter and upwind from it.

An example of this would be alder which was picked up only in small quantities at our station (Figure 3), but if a patient had an alder tree outside his window obviously he would be exposed to more such pollen and this may be an important cause of symptoms.

It has become customary to test and treat patients with tree mixtures containing six (ash, beech, birch, hickory, oak, and poplar) or eight—adding elm and maple—families of trees. This practice is inadequate. Not all these pollens are equally important causes of symptoms in this area. Ash and hickory, although present, are rare causes of symptoms in this area. On the other hand, pollens such as elm and maple (which are not included in the six tree mixture), or mulberry and alder which are not in any of the mixtures, are all common in this area and studies[5] have shown probably are significant in causing symptoms.

Rachemann in 1936 reported the antigenicity of different orders of trees to be unique and this has been recently confirmed by Siegel,[6] *et al.* Siegal[6] showed only minor cross antigenici-

ty among the orders of trees while there was considerable crossing among families. If a patient is allergic only to one of the six trees he is getting in the tree mixture, he is being injected with much useless and potentially dangerous foreign antigen. Thus if he is allergic to oak only, in three thousand Protein Nitrogen Units (PNU's) of a six tree mixture he is receiving only five hundred PNU's of oak. Therefore, a patient maintained every four weeks on three thousand PNU's of such a mixture receives a yearly dose of oak of only six thousand PNU's. From the figures of Lichtenstein[7], for ragweed at least, a yearly dose of six thousand PNU's is inadequate for hyposensitization.

Basically, there are two ways for a plant to pollinate. First are those that are cross pollinated by insects and have heavy sticky pollens associated with colorful fragrant flowers. These pollens being too heavy and large (750 micra) to be wind blown usually do not cause symptoms. Examples of this are willow and linden[9]. Plants that cause allergy symptoms have inconspicuous flowers and must depend on the wind to disperse their pollen which are usually light, small, and produced in large quanities. Conifers such as cedar and pine product large amounts of light pollen but do not usually cause symptoms due to their thick exorine.[10] One exception to this is the mountain cedar around Texas.

Oak, which is of the same family as beech, probably is the most important hayfever producing tree in this area. Many oak trees are present throughout this area and spread pollen in great numbers over a long period of time (Figure 3). Poplar is of the same family as the insect pollinated willow. On the other hand, sweetgum, walnut, hickory, ash, and sycamore are probably of little importance.

Finally, a comment is in order about the significance of the daily pollen count. An absolute number is of no significance to the patient on a given day. We (and many others in the past) placed slides at two different but fairly close locations and the variation in the count was great.[11] The public announcement of a pollen count can only lead to psychosomatic rhinitis and in this respect is a disservice. A pollen that is present over a long period of time (such as the oak) will give more symptoms than one that may be present for a short time in greater numbers. Connell[12] has shown that small exposure to a pollen may not cause symptoms at first, however, after a period of time the same number of pollen grains will give significant symptoms. The pollen survey is useful only for its qualitative results. By correlating a patient's symptoms with the pollens present at that time and skin tests, a more accurate diagnosis may be made.

Summary

Trees are a major cause of seasonal allergic symptoms in northern New Jersey. Eighteen different pollens were collected in the present survey over an eleven-week period, not all of them having the same significance in causing symptoms. The use of stock tree mixture for diagnosis and treatment is inadequate and should be abandoned. The medical profession is probably doing a disservice to its patients by allowing the mass media to publish daily counts. Attempts should be made to correlate the time of symptoms with the pollen present at that time.

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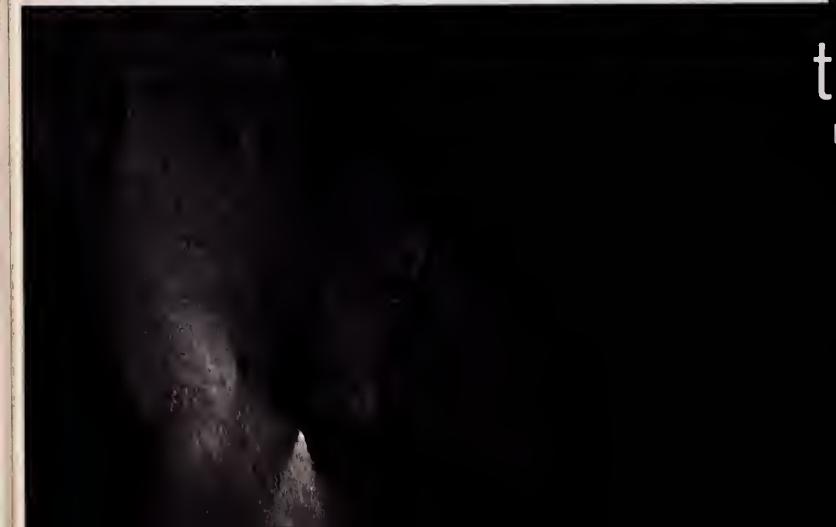
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Hydrogenated ergot alkaloids were found effective in relieving symptoms of cerebrovascular insufficiency in the elderly.

Chronic Cerebrovascular Insufficiency in the Elderly

Perspectives on Treatment

Herbert J. Rosen, M.D./Dover

The syndrome of chronic cerebrovascular insufficiency (CVI) is a disorder encountered with increasing frequency in aging persons. Although cerebral arteriosclerosis is the pathological process most often implicated, chronic CVI may well have varying and mixed etiologies, such as diminished cardiac output, anemia, hypoxia, or intracellular neuronal disorders. Clinically, its onset and development are generally insidious, and its symptomatology may be wide-ranging, covering the spectrum of physiologic, psychologic, and behavioral manifestations.

Presenting complaints, in many patients with chronic CVI, may be of recurrent episodes of dizziness, insomnia, and fatigability. Many demonstrate irritability, mood changes, and complain of increasing difficulty in doing previously simple tasks, such as eating and dressing. Very often the prominent symptomatology consists of transient periods of confusion and disorientation and episodes of memory loss and poor intellectual function.

Physical examination and laboratory studies often reveal coexisting disorders that are common to geriatric populations, such as generalized arteriosclerotic disease, osteoarthritis, and anemia. Some degree of hypertension may be detected and, occasionally elevated blood-sugar levels are found. Careful questioning of the patient's family or close social contacts often reveals a rather characteristic picture: the patient, for some time, has experienced intermittent periods often rapid in onset, of progressive physical and mental decline, interspersed with relatively stable periods of partial to almost full remission.

The frequent relationship between cerebral arteriosclerosis and chronic CVI has long been known and therapeutic efforts have generally been directed toward finding methods of increasing the intracerebral circulation. Vasodilator drugs, while at first glance a seemingly reasonable choice, have proved unrewarding more often than not, and, therefore, are not widely accepted. This may well be because the net hypotensive effects of vasodilator drugs may actually result in decreased, rather than improved, intracerebral blood flow. As an alternative approach, based on the findings reported in several pharmacologic and clinical studies,[1, 2, 3, 7] we chose to investigate the use of dihydrogenated ergot alkaloids* as part of a total health maintenance program for patients we recognized as having chronic cerebrovascular insufficiency.

Fifty-one patients, ranging in age from 65 to 93 (average, 72), participated in our study. These included 27 women. Forty-nine patients were ambulatory and living at home; one patient was hospitalized and the other a nursing home resident.

Our comprehensive health survey revealed

*Hydergine (Sandoz Pharmaceuticals)—Dihydrogenated ergot alkaloids.

numerous medical problems in this geriatric population (Table I), with arteriosclerotic disease predominant. Each patient also manifested some of the more characteristic symptoms of cerebrovascular insufficiency, among them confusion, impairment of recent memory, lack of mental alertness, and mood fluctuations.

Table I

Predominant Medical Problems
in 51 Patients

	No. of Patients
Cerebrovascular Insufficiency	51
Arteriosclerotic Cardiovascular Disease	47
Osteoarthritis	18
Anemia	18
Hypertension	4
Hypertensive Cardiovascular Disease	1
Localized Arterial Insufficiency	1
Rheumatic Heart Disease	1

Over a 12-week period each patient was given two sublingual tablets of Hydergine®* (0.5 mg) three times a day at mealtime (3 mg per day). Thirty-four patients were given Hydergine®* exclusively, while seventeen also received other drugs for specific medical problems or occasional night-time sedatives. Since any evaluation of the action or effects of the drug might be influenced by concomitant medication with psychoactive agents, daytime sedatives, or known vasodilators, we did not treat any patient on a regular basis with such drugs during the present study.

In addition to medication, a substantial degree of ego-supportive psychotherapy was provided to every patient. In essence, this took the form of genuine interest, recognition, concern, and encouragement by the physician and his medical assistant, and, in most cases, by members of the patients' families, as well.

Before treatment with Hydergine®* was initiated, and at three four-week intervals during the study, the physician recorded several assessments for each patient. The first was a rating of symptom severity, based on a list of 17 symptoms most commonly observed in patients with CVI (see Table II). The second was an assessment of the patient's over-all clinical condition. The scoring system used for both ratings ranged from 1, for "normal" or "no symptom", to 7, for "markedly abnormal".

In addition, the physician recorded several assessments of each patient's over-all therapeutic response since the start of the study. These "global change" ratings were made at regular intervals throughout the study: after 4, 8, and 12 weeks of treatment. The scoring system was a seven-point scale ranging from

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Table II

Symptomatic Changes
Pretreatment vs Final Rating at Week Twelve

Symptom	No. Patients with Symptom	Average Severity Pretreatment	Average Improvement by Week 12†
Mood-depression	50	5.8	3.9
Confusion	45	5.0	3.2
Impaired Mental Alertness	47	5.5	3.2
Impaired Motivation—Initiative	47	5.9	3.7
Irritability	51	6.3	4.1
Memory Deficit	51	6.2	3.4
Bothersomeness	46	4.7	1.9
Indifference to Surroundings	38	5.1	1.9
Unsociability	48	4.9	2.2
Uncooperativeness	46	4.4	1.8
Emotional Lability	51	5.3	2.8
Fatigue	49	5.9	3.2
Poor Self-Care	11	4.2	1.6
Appetite (Anorexia)	24	4.3	1.5
Dizziness	47	4.5	3.2
Nocturnal Cramps	30	5.0	3.2
Paresthesias	33	4.9	3.4

Scored as 1 = Normal, 3 = Mildly Abnormal, 5 = Moderately Abnormal, 7 = Markedly Abnormal, †All average improvements statistically were significant.

—3 ("very much worse") through 0 ("no change") to +3 ("very much improved"). Finally, we measured and recorded each patient's blood pressure before and at three four-week intervals during the study.

Results

Table II summarizes the symptomatic changes we observed in our 51 patients by the end of the twelve-week study. Statistical analysis showed that the severity of all 17 symptoms was reduced significantly. Most impressive results were noted in the patients' mental alertness, confusion, fatigue, and nocturnal cramps. In clinical terms, these improvements were meaningful. For example, patients whose motivation, memory, or mental alertness had been moderately to markedly impaired prior to treatment (scores of 5.5 to 6.2) demonstrated only mild impairments (scores of 2.2 to 2.8), in these areas, after treatment.

Such symptomatic improvements were reflected in a larger scale by a salutary progression in the patients' over-all clinical status. On an average, before treatment, the patients' conditions were considered moderately abnormal (score of 5.5), but only mildly abnormal (2.3) at the conclusion of twelve weeks of treatment.

The final measure of therapeutic effect, the physician's rating of global change (Table III) provided both a qualitative and quantitative indication of patient response. After four weeks of treatment, some degree of therapeutic response was seen in 42 of the 50 patients for whom these ratings were complete; most (68 per cent) were "slightly" to "much improved." Within four more weeks, all 50 patients had responded to some extent; 28 patients (57 per cent) were "very much improved" and 22 (43 per cent) were "slightly" or "much improved." By the end of the twelve-week treatment period, 41 patients (82 per cent) had attained the highest level of response, "very much improved," while the remaining nine patients were "much" or "slightly improved."

Table III

Therapeutic Response:
Global Change Ratings after 4, 8, and 12 Weeks of Treatment in 50 Patients**

Rating	Number of Patients		
	Week 4	Week 8	Week 12
Very Much Improved (+3)	8 (16%)	28 (57%)	41 (82%)
Much Improved (+2)	16 (31%)	15 (29%)	7 (14%)
Slightly Improved (+1)	18 (37%)	7 (14%)	2 (4%)
No Change (0)	8 (16%)		
Slightly Worse (−1)			
Much Worse (−2)			
Very Much Worse (−3)			

**Ratings complete for 50 of 51 patients

Discussion

Our general approach to patient care is one of ongoing total health maintenance. A major objective, accordingly, is to *prevent* health crises whenever possible. This we attempt to accomplish by early recognition and management of all factors that may adversely affect the individual's future health. We give special attention to psychosocial and environmental factors, since problems in these areas seem to exert a profound effect on total health status (particularly in elderly patients), yet are so often neglected. Experience has repeatedly demonstrated to us the great value of supportive psychotherapy not only by the medical team, but also by the family's demonstration of interest and understanding of the older patient and his special problems. In this study, such supportive care was provided to the majority of patients.

A direct evaluation of the effects of such nonpharmacologic treatment factors, while highly desirable, was not feasible in this study. However, the provision of ego-support and encouragement by the medical team and family, we are convinced, contributed materially to our patients' excellent response to the pharmacologic regimen. In this regard, we feel that a systematic evaluation of the quantitative as well as qualitative effects of psychological support in the geriatric patient would constitute a worthwhile clinical investigation.

In general, the results of our study of a preparation of dihydrogenated ergot alkaloids*

*Hydergine (Sandoz Pharmaceuticals)—Dihydrogenated ergot alkaloids.

in 51 geriatric patients are consonant with those reported by other investigators.[1, 2, 5] All manifestations of our patients' abnormality—physical, cognitive or intellectual, and behavioral—were alleviated to a statistically significant degree. Usually, symptoms which were both predominant and severe showed the best improvements, including irritability, confusion, depressive mood, and impairments of memory, mental alertness, and motivation.

Like Triboletti and Ferri,[2] we found that our patients also exhibited a tendency for steady, progressive improvement throughout the treatment period. For example, 16 per cent of the patients were "very much improved" after four weeks and this increased to 57 per cent after eight weeks, and 82 per cent after twelve weeks. These observations suggest that even greater therapeutic effect might be realized with continued treatment.

The possible mode of action of this preparation of dihydrogenated ergot alkaloids* in patients with symptoms of CVI is of particular interest to us. Animal investigations[6] have led to the theory that Hydergine®* acts primarily by improving cerebral metabolism. In effect, it is believed that an intracellular metabolic improvement induces a sequence of changes in the structural morphology of both astrocytes and capillaries, which finally results in reduced vascular resistance and increased intracerebral blood flow.

This theory, then, discounts primary vasodilatation as the mechanism by which cerebral circulation is improved in patients given Hydergine®*. Consequently, it suggests to us that "cerebrovascular insufficiency" may be a misnomer, and that we may actually be dealing with an unrecognized general or localized metabolic disorder, rather than a primary malfunction of circulatory regulation. Indeed, a more appropriate term may be "cerebrometabolic insufficiency."

We would hope that appropriate laboratory and clinical studies will be performed to further explore the mode of action of dihydrogenated ergot alkaloids,* for the results may well suggest still more promising alternatives for aged patients, and may also help further clarify the insidious and often elusive nature of the syndrome now termed chronic cerebrovascular insufficiency.

*Hydergine (Sandoz Pharmaceuticals)—Dihydrogenated ergot alkaloids.

Summary

A study was conducted with 51 geriatric patients to evaluate the efficacy of a preparation of dihydrogenated ergot alkaloids* in relieving the symptoms of chronic cerebrovascular insufficiency (CVI). Hydergine®* (0.5 mg sublingual tablets) was administered to the patients at a dosage of one milligram three times a day for twelve weeks as part of a total health maintenance program. Results were evaluated by periodic ratings of symptom severity, over-all clinical status, and global change in each patient's condition. Seventeen target symptoms were improved to a statistically significant degree by the end of the twelve-week study, with best results noted in mental alertness, confusion, memory, irritability, depressive mood, motivation-initiative. paresthesias, fatigue, and nocturnal cramps. By the conclusion of treatment, 82 per cent of the patients were described as "very much improved."

Aspects of the investigator's "ongoing total health maintenance program" for elderly patients are described and a brief discussion of the possible etiology of CVI is also presented.

Acknowledgment—The author wishes to express his appreciation for the invaluable assistance of Mrs. Valerie Mieles in the conduct of this study.

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77 Union Street

Substernal Goiter Associated with Recurrent Syncope and Stroke*

Sylvan E. Moolten, M.D./New Brunswick

The danger of permitting adenomatous goiters to become intrathoracic is too often insufficiently recognized by physicians. Failure to remove an adenomatous goiter extending beneath the clavicles and sternum, yet not deeply intrathoracic, exposes the patient to the risks of such a goiter entering the mediastinum so that it becomes impacted and, therefore, increasingly difficult to remove surgically and that much more dangerous.[1]

The best known complication of intrathoracic goiter is tracheal compression and lateral deviation. This produces the "scabbard trachea," which may result in obstruction to respiration. Eventually the patient may find it difficult to breathe, particularly on exertion. He may also find that he is unable to bend over or to turn his head freely without producing respiratory obstruction as the adenoma impinges on the right or left first rib, which serves as a fulcrum to exert pressure on the partially collapsed trachea.

Another major effect of intrathoracic goiter is partial obstruction to the return of venous supply from the head and neck by pressure on the internal jugular veins. This may be evidenced by dilation of the superficial veins of the upper part of the chest and neck and eventually by edema of the face and other features of the superior vena caval syndrome.

The tendency of intrathoracic goiters to enlarge progressively, especially as colloid cysts form and where there is complicating hemorrhage, adds to the threat. Secondary fibrous encapsulation and dense fibrous adhesions by which the adenoma and surrounding structures are matted together in the mediastinum magnify considerably the risk of surgery.

Other complications include thoracic pain suggestive of atypical angina pectoris[2] and esophageal obstruction.[3] In one patient[4] intrathoracic goiter resulted in obstruction of a bronchus with secondary development of cystic bronchiectasis. It is surprising that the textbooks and available literature fail to mention the possibility of circulatory complications, particularly interference with the blood flow to the brain as the result of compression of the arteries arising from the arch of the aorta. The following case, although incompletely documented, suggests this possibility.

An 82 year old housewife was admitted to the Roosevelt Hospital with left-sided hemiplegia and general deterioration. The history as given by the family indicated that her illness began ten years previously with "fainting spells" followed by gradual onset of paralysis on the left side of the body. She seemed to be doing well until two months before admission when, at times, she became confused, increasingly deaf, and weaker. On admission, she was bedridden, hemiplegic, and incontinent of urine and feces. Skin and mucous membranes were pale. She presented mild ankle edema and diminished breath sounds and vocal fremitus in the left hemithorax. There was no evidence of enlarged thyroid or enlargement of lymph nodes. The blood pressure was 170/80, the hemoglobin 11.3 Grams; hematocrit was 31; WBC 6,600; neutrophiles 35-3; lymphocytes 56. The fasting blood sugar was 103. Blood urea nitrogen was 21. The urine contained 4 plus protein and large numbers of leukocytes. X ray revealed evidence of substernal thyroid causing much deviation of the trachea toward the right. The heart appeared enlarged in its transverse diameter. The trachea seemed narrowed. Her course in the hospital was relatively uneventful during the ensuing 18 months. The systolic blood pressure remained somewhat elevated but the diastolic pressure was normal (188/82 and 170/80). Proteinuria, pyuria, and edema

*From the Roosevelt Hospital Metuchen, New Jersey.

of the legs persisted. Eventually bronchopneumonia developed involving chiefly the right lung with fatal outcome.

Autopsy Findings: The larynx and trachea were remarkable for the presence of the enormous size of the thyroid, which weighed 113 Grams, the greater enlargement involving the left lobe, which measured 10 by 6 centimeters. The entire gland was unusually firm. Cut section revealed nodular transformation accompanied by areas of marked fibrous induration with focal calcification and a few cysts. The thyroid mass was tightly adherent to the trachea over a segment of 3 centimeters in length, where tracheomalacia had resulted in sufficient measure to permit the trachea to be bent easily from side to side and from before backward because of advanced atrophy of the tracheal cartilages. The lumen was moderately narrowed but could be easily stretched. Microscopically the thyroid follicles were distended with well-stained colloid. Many follicles were cystic and atrophic and replaced by large irregular scars.

The lungs were unusually bulky with hyperinflation and were fluffy and light in weight, together weighing 750 Grams. A few large thin-walled cystic bullae were found along the free borders, especially in the lower lobes anteriorly. Scattered small emphysema cysts and bullae were present in the remaining portions of both lungs, especially in the upper lobes. Small amounts of aspirated gastric contents were present in the tracheobronchial tree, the lumen of which was slightly widened throughout. The pulmonary arteries exhibited atherosclerosis and no emboli. The lungs showed considerable panlobular emphysema with striking overdistention of alveolar ducts and bronchioles, many of which were actually cystic. Scattered scars were present throughout both lungs within which iron-encrusted pigment granules were deposited. The interstitial framework contained numerous small lymphoid deposits. Patchy bronchopneumonia was present in several areas containing foreign body granulomata and aspirated material resembling vegetable cells.

The heart was somewhat enlarged (450 Grams) as the result of pronounced hypertrophy of both ventricles, especially the right, which averaged 6 millimeters in thickness. The left ventricle averaged 18 millimeters in thickness. Coronary arteries were widely patent throughout and stippled with slight atheroma. The aorta was moderately dilated, especially proximally, and exhibited advanced atherosclerosis in its distal portion with eggshell calcification in the lower abdominal segment. Some atherosclerosis and calcification were present at the root of the aorta and at the ostia of the major branches arising from the arch. Other findings were relatively insignificant except for advanced pyelonephritic contraction of both kidneys and decubitus ulcerations of the left heel and right leg.

Clinical Diagnoses were recurrent syncope culminating in left hemiplegia; decubitus ulceration of left heel and right leg; arterial hypertension (systolic hypertension) with high pulse pressure; cerebral thrombosis; and intrathoracic goiter.

Anatomic Diagnoses were massive nodular adenomatous hypertrophy of thyroid (weight 113 Grams) with marked tracheomalacia secondary to pressure of substernal adenomatous goiter and resulting partial obstruction causing hyperinflation of lungs; panlobular emphysema with focal bullous emphysema; pronounced hypertrophy of right ventricle; advanced chronic pyelonephritis; and moderate hypertrophy of the left ventricle.

Because of the limitations of the autopsy permission, the brain and carotid arteries in the neck were not examined so that it is impossible to be certain that the hemiplegia in this case arose entirely on the basis of intrathoracic pressure by the goiter on the innominate or right common carotid artery. The atherosclerosis of the aorta and its branches is consistent with an assumed atherosclerotic narrowing of the carotid arteries in the neck, as well as in their intracranial ramifications. Perhaps the most compelling evidence implicating the goiter in the production of hemiplegia is the clinical history of "recurrent

fainting spells" over a period of ten years and gradual onset of paralysis on the left side of the body. One is reminded of the cases of Marmor and Sapirstein[5] and of Zeman and Siegal[6] in which cerebral thrombosis followed stimulation of the hyperactive carotid sinus in elderly patients with cerebral arteriosclerosis. The substernal location of the goiter precludes the possibility of the carotid sinus syndrome specifically as the mechanism of hemiplegia in this case. On the other hand pressure within the mediastinum against the arch of the aorta may easily be held responsible for eliciting a depressor reflex from the aortic nerve plexuses capable of inducing recurrent syncope and thereby predisposing eventually to cerebral thrombosis in a patient with cerebral arteriosclerosis. Under the existing circumstances it was not feasible to determine which of these two possibilities was responsible.

I have encountered two other instances at autopsy in which large goiters were apparently responsible for a stroke. One was in a 75-year-old woman who had had goiter for at least 25 years. She had been treated also for hypertension. Death resulted from recurrent massive encephalomalacia. The goiter had compressed the trachea markedly from side to side with angulation toward the right. The lungs were hyperinflated throughout. The carotid arteries on each side were displaced and moderately compressed by the thyroid masses, especially on the left side.

In the second case, a 67-year-old woman had signs of cerebral vascular insufficiency which developed gradually and in fluctuating intensity. The thyroid was enlarged to about two and a half times normal, chiefly on the left side. Carotid arteriography revealed no evidence of displacement or obstruction of the cerebral vessels. At autopsy, massive encephalomalacia was found in the left parietal and temporal lobes extending into the left frontal lobe. The softening was confined largely to the deeper cortical areas of the left hemisphere without apparent involvement of the superficial cortex. The thyroid was found to be about 4 times the normal size and weighed 115 Grams. Much of this gland was fibrous and cystic. Many follicles were distended with recent hemorrhage. The carotid arteries on either side of the thyroid gland were patent and of normal caliber and presented no significant atherosclerosis or evidence of old or recent closure. It was learned later that the patient had been aware of the mass in her neck for about 20 years. The interesting feature in the second case was the limitation of encephalomalacia to the subcortical zones, reminiscent of the phenomenon of subendocardial necrosis of the heart muscle in patients with coronary insufficiency. Accordingly, it was postulated that episodes of *relative* carotid artery narrowing induced by the goiter had led to periodic incomplete vascular insufficiency of the brain. Conceivably the same mechanism of intermittent relative cerebral vascular insufficiency (caused by remote intermittent compression of the innominate or common carotid artery in the mediastinum) may have been accountable for the gradual but progressive cerebral deterioration in the present case.

Summary

A case of intrathoracic goiter is reported in which the patient suffered from repeated "fainting spells" over a period of 10 years culminating in left hemiplegia. Severe tracheomalacia was present. It is suggested that giant or intrathoracic goiter may be a cause of stroke when it produces intermittent partial obstruction of a carotid artery in the course of a number of years.

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The role of the adrenals in peptic ulcer is here explained.

The Adrenals and Chronic Ulcer Disease*

Eddy D. Palmer, M.D./Long Valley

The most important gastroduodenal responsibility of the pituitary-adrenal axis is control of the distribution of blood within the segment's mucosa. This controls the secretion of acid, pepsin, intrinsic factor, gastrin, secretin, pancreozymin, and other enzymes and hormones. The adrenal hormones manage all this simply by causing the mucosa's arteriovenous anastomoses to open or to close, thereby rendering the secreting mucosa bloodless or plethoric. The observations of Dolcini and colleagues[3] on rats were basic: a striking increase in the amount of blood flowing through the gastric mucosa upon adrenal stimulation by ACTH. They found that the mucosa became bloodless following adrenalectomy. Clearly, in these rats, adrenal hormones caused the gastric arteriovenous anastomoses to shut, forcing the mucosal capillary route on the mural arterial blood flow. Absence of adrenal secretion permitted the anastomoses to open, rendering the mucosa bloodless.

In view of the influence of adrenal hormones over mucosal perfusion, chronic ulcer should not form and, coincidentally, gastric secretion should become depressed when adrenal function fails. Gray,[7] in 1960, made the now famous observation, "no adrenal, no ulcer." It was not literally true, of course, but does emphasize an important generality. Be careful to distinguish chronic ulcer from acute ulcer and erosion. In one series of 160 cases of adrenal insufficiency there were three instances of gastric ulcer,[14] and in another series of 363 chronic ulcer could be identified in three.[10]. Sparberg[15] described chronic duodenal ulcer in a patient with untreated Addison's disease.

That patients with hypoadrenalism are not rendered permanently resistant to chronic ulcer is shown by the observation that some develop ulcer while under cortisone replacement therapy.[4, 5, 8, 10] Gray[7] told of seven patients with Addison's disease who developed chronic gastric or duodenal ulcer after two or three years of maintenance cortisone.

But in Cushing's hypercorticism, too, chronic ulcer is rare.[11, 12] Zollinger's [17] incidence figure was a generous one per cent. The studies of Cummins and Gompertz[2] uncovered nothing to support the concept that adrenocortical hyperactivity is in any way etiologically involved in "ordinary clinical ulcer disease."

Depressed adrenal function results in depressed gastric secretion, as expected.[7, 10] In both humans and experimental animals the evidence suggests that the native adrenal steroids function not only by permitting gastric acid secretion to be normally active but also by allowing an augmented secretory response to vagal, histamine, and antral stimulation. Gray[9] summarized: "Thus the adrenal gland functions as an agent which 'permits' a gastric (acid secretion) response to occur; without its presence the response could not occur."

The observations that pertain to acute gastroduodenal ulcer and erosion, as opposed to

* Condensed from a Clinical Projects Report, read to the New Jersey Chapter, William Beaumont Society, October 13, 1971, Newark.

chronic ulcer, are quite different. Here the problem becomes caught up in the complexities of stress, a matter wholly separate from the self-perpetuating lesion that is chronic ulcer. Back in 1916 Mann[13] reported that acute ulcers are found in 90 per cent of adrenalectomized animals at the time of their spontaneous death. Woldman and colleagues[16] found that damage to the adrenals produces a high incidence of acute ulcerative lesions in the gastrointestinal tract of man, too. In the course of autopsies, they observed acute ulcers or erosions in 19 per cent of patient who had normal adrenals, 27 per cent of those with mild adrenal abnormalities, and 46 per cent of those with severe adrenal destruction.

When adrenal function and histopathology are studied among patients with chronic ulcer, results are confusing. Biggart and Willis[1] found that adrenal disease was more prevalent at the autopsy of patients with chronic ulcer than among controls. Gray[6] observed that adrenal corticoid levels in blood and in urine are not increased in ulcer patients, confirming the failure of Cummins and Gompertz[2] to demonstrate alterations in adrenocortical activity in ulcer patients.

Summary

The clinician can learn from these observations that—to paraphrase Gray—by controlling gastroduodenal perfusion, the adrenals function to permit chronic gastroduodenal ulcer to develop and to persist, but that native adrenal secretions, however overabundant, cannot be blamed for chronic ulcer disease.

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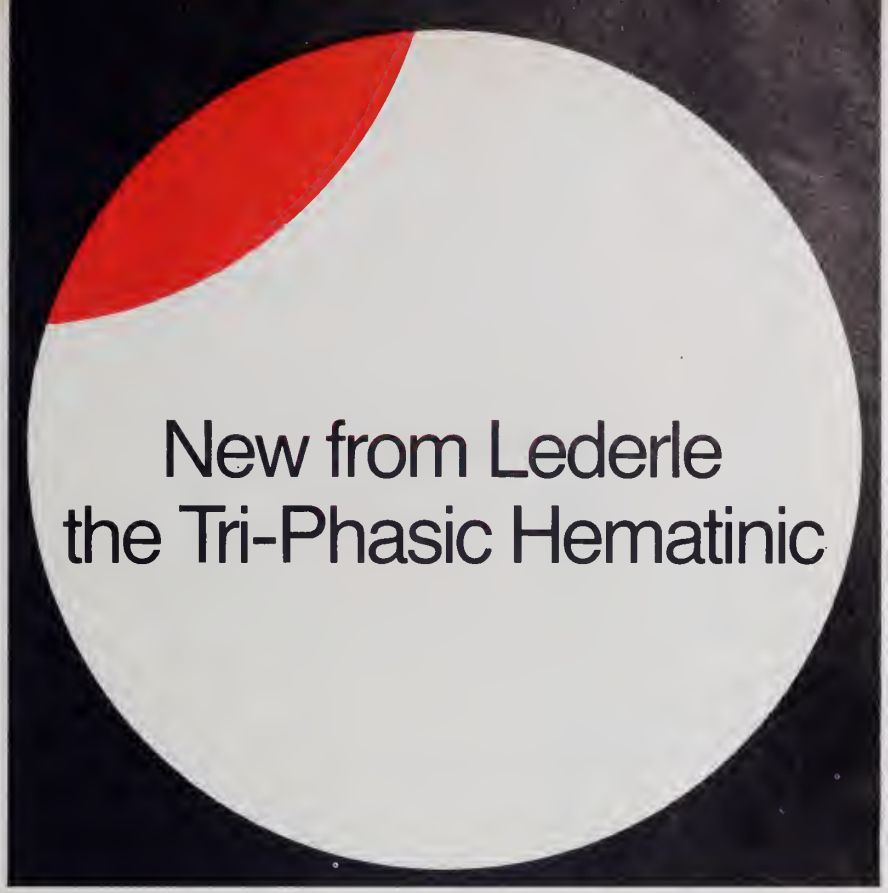
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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

Regular meetings of the Board of Trustees were held on February 27 and March 19 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

February 27, 1972

AMA Conference for Medical Executives . . . Received a report from the Executive Director on the AMA Conference for Senior Medical Executives held in Chicago on January 27 and 28. Among topics of major discussion were the need for increased AMA communication with members, expansion of service to members, phase II of wage-price controls, steps that state and county societies can take to encourage greater medical student, intern, and resident involvement in organized medicine, and the 7 per cent decrease in dues-paying members—the AMA Board of Trustees has approved a membership recruitment program (at a cost of $150,000) which will be coordinated with state medical societies.

Centenary Celebration . . . Received a report from the Executive Director that he had accepted an invitation from the Commissioner of Health to serve as a member of the Centenary Celebration Committee of the American Public Health Association, whose primary function will be to plan commemorative activities, including an exhibit and a dinner honoring the APHA, and to explore ways of achieving financial support.

AMA-AMPAC Public Affairs Workshop . . . Concurred in the President's action authorizing the attendance of the MSNJ Conference Committee with JEMPAC at the AMA-AMPAC Public Affairs Workshop to be held in Washington, March 11 and 12—Second Vice-President, Chairman of Council on Medical Services, Chairman of Council on Legislation (Francis A. Pflum, M.D. will attend for the Council on Legislation).

Workshop on Accreditation . . . Concurred in the President's action approving MSNJ's cosponsorship (without financial commitment), with the New Jersey Hospital Association, of a workshop on new standards for accreditation, to be conducted by the Joint Commission on Accreditation of Hospitals, April 26 and 27 in Morristown.

Congress on Socio-Economics of Health Care . . . Authorized President-Elect D'Elia to attend (with expenses paid) the 6th National Congress on Socio-Economics of Health Care to be held April 6 to 8 in Fort Lauderdale, Florida.

Conference of State Mental Health Representatives . . . Authorized the Chairman of the Council on Mental Health (Dr. Garber) to attend (with expenses paid) the Annual Conference of State Mental Health Representatives, April 13 to 15 in Scottsdale, Arizona.

Advisory Council on "Nurse Pediatrician or Pediatric Nurse" . . . Designated Harold L. Colburn, Jr., M.D. as MSNJ's representative to the Advisory Council on "Nurse Pediatrician or Pediatric Nurse," which is under the aegis of the Department of Community Medicine of Rutgers University.

AMA Council on National Security . . . Authorized the forwarding of the name of James W. Ralph, M.D. of Englewood to the AMA in nomination for membership on the AMA Council on National Security.

Menorah Medical Center . . . Authorized the attendance (with expenses paid) of the Chairman of the Committee on Medical Education at the survey-inspection of the Menorah Medical Center in Kansas City, Missouri, on March 15.

Council on Legislation . . . Approved, as amended, the report of the February 10th meeting of the Council on Legislation.

1. *Ad Hoc Subcommittee to Review Council's Systems and Procedures* . . . Voted to commend the subcommittee on its report and to approve, as amended, the following recommendations contained therein:

a. That a sixth official position concerning legislation be added to the five already used by the Society—*CONDITIONAL APPROVAL,* because . . . (here the reasons should be given upon which the approval by the Society is conditioned).

b. Because of the new Lobbying Law it is recommended that the two physician-members designated as Legislative Educational Representatives of the Society no longer be asked to attend sessions of the legislature, but that Mr. Meara, as the Society's Legislative Consultant, be used for any necessary contacts by the Society with legislators in the course of the legislative sessions.

c. For the same reason, all messages to the legislators should be issued over the name of either the President of MSNJ or the Chairman of the Council on Legislation rather than that of the Executive Director, who as a paid employee would be subject to consideration for registration under the Lobbying Law.

d. That a Conference Committee should be formed consisting of selected members of the Council on Legislation and the two former Legislative Educational Representatives, whose duty it will be to make themselves available to discuss bills with their legislative sponsors or to attend committee hearings concerning bills of medical interest.

e. In instances in which the Society seeks conference contact with legislators, Mr. Meara should be asked to arrange the time and place.

f. A special group of Society representatives, each of whom is *persona grata* to the Governor, should be designated **by the President** to meet with the Governor, by official arrangement from time to time, in behalf of the Society's legislative interests. (Boldface indicates Board amendment.)

g. That specialty societies continue to be invited to send representatives to all meetings of the Council on Legislation and that presidents-elect **or chairman of legislative committees** of component societies be also invited to attend. (Boldface indicates Board amendment.)

h. The Committee recommends that at each session of the Board of Trustees at which a report is to be presented from the Council on Legislation, either the Chairman or the Vice-Chairman of the Council attend to present the report and discuss its contents.

i. The Committee further recommends that in the occasional instance in which the Board finds itself disposed not to approve a position **as initially** recommended by the Council, the Board adopt a position of "DEFERRED BY THE BOARD OF TRUSTEES, because . . ." and return the bill to the Council for reconsideration. (Boldface indicates Board amendment.)

j. It is further recommended that **except in an emergency** the Board make it a policy not to consider and act upon legislative measures that have not yet been before the Council on Legislation. (Boldface indicates Board amendment.)

2. *Current State Legislation* . . . Approved the Council's recommended positions on current state legislation except for that on S-42 (see Board amendment under S-42 below).

S-3 —To provide that the advisory council on education of the handicapped children will consist of public and private professional and lay interests. *APPROVED*

*S-8 —To require boards of education to identify children between ages 3 and 5 years who require special education to prevent more debilitating handicaps and to permit establishment of suitable facilities, programs and special services including summer classes for such children. *APPROVED*

*S-9 —To create and establish a risk register for handicapped and high risk children in the Department of Health. *DISAPPROVED,* because it would be impractical of implementation because of its broad application and furthermore would lead to the necessary stigmatization of a potentially handicapped child and might also cause a great deal of undue anxiety in some parents.

S-14 —To require local boards of health to notify persons bitten by an animal whether such animal is or is not affected by rabies within 12 hours after such determination. *APPROVED*

*S-42 —To permit application to the Board of Medical Examiners for exemption from licensing under the act concerning practice of medicine and surgery by persons holding an M.D. degree in the employ of a licensed hospital and performing services under direct supervision of licensed physicians. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

NOTE: The position indicated on S-42 is as amended by the Board. The Council had recommended a position of "conditional approval."

*S-53 To provide that any person who fails to clearly advertise or label poisonous or deleterious substances for household use without disclosing the generic names of ingredients shall be a disorderly person. *APPROVED*

*S-132 —To provide that it shall be a disorderly persons violation for anyone to abandon any disposable or reusable hypodermic needle or syringe without first destroying it. *DISAPPROVED,* because although the intent of the legislation is laudable, the measure imposes a disproportionate burden upon patients and physicians alike in the probably

* All bills marked thus are identical with bills of last year whose official positions were the same.

vain hope of limiting and measurably restricting the activities of illegal users of drugs.

S-180 —To authorize a $25,000,000 bond issue for establishment of education facilities for the multiple or severely handicapped children. *APPROVED*

*S-196 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten. *DISAPPROVED*, because under certain circumstances immunization against rubella is contraindicated.

*S-198 —To provide for the "Noise Control Act" and to empower the Department of Environmental Protection to promulgate codes and regulations and to appropriate $100,000. *APPROVED*

*S-208 —To provide for the establishment of air pollution control commissions in the counties individually and jointly. *DISAPPROVED*, because there is no evidence that at the present time the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Environmental Protection. Moreover, the prevailing unified control would be jeopardized.

S-214 —To provide that any fresh meat sold at retail shall be wrapped in an entirely transparent container. *APPROVED*

*S-218 —To provide that no dog brought to a pound or shelter shall be sold or otherwise be made available for experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

*S-233 —To provide that it shall be a high misdemeanor for any person to add any controlled dangerous substance defined in R.S. 24:21-2 to any food or beverage knowing that such may be consumed by other persons not knowing such food or beverage has been so adulterated. *APPROVED*

*S-238 —To provide for the establishment of a central registry of blood donors in the Department of Health and to appropriate $50,000. *DISAPPROVED*, because it would be a duplication of record keeping by existing blood banks in the State of New Jersey with no appreciable advantages.

*S-242 —To authorize the Commissioner of Health to contract with voluntary, non-profit hospitals for early care, treatment, rehabilitation, counseling and education of drug users and their families and to appropriate $150,000. *APPROVED*

*S-243 —To establish a Health Hazard Abatement Fund where municipalities may make application for State aid to defray expenses incurred in abating conditions harmful to the health and safety of occupants of buildings regulated by such municipalities. *NO ACTION*

S-252 —To direct the Department of Health to establish a program for the care and treatment of persons suffering from terminal illnesses and to appropriate $500,000. *APPROVED*

S-253 —To direct the Department of Health to establish a program for the care and treatment of children suffering from terminal illnesses and to appropriate $500,000. *APPROVED*

*S-263 —To include in the definition of optometry one who sells, at retail, to the general public spectacles or eyeglasses containing other than plane lenses; to provide that nothing in the definition of optometry shall prohibit a duly licensed opthalmic dispenser from providing eyeglasses as prescribed by an optometrist or physician. *DISAPPROVED*, because the vending of such glasses is not proper or exclusive to the practice of optometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.

*S-295 —To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

S-317 —To provide for the regulation of clinical laboratories and their personnel. *DISAPPROVED*, because (1) it is in conflict with, but fails to repeal the Bio-Analytical Laboratory and Laboratory Directors Act (C-45:9-42.1, *et seq.*); (2) it would permit specialists proficient only in narrow limits of clinical testing to direct laboratories and the work of others in areas they are incompetent to assess. (3) it would require licensing of all technical laboratory personnel, thus restricting recruiting, increasing costs, and disregarding the fact that the Report of the Bateman Commission urged *less* not more licensure; (4) it is discriminatory in that physicians in solo practice are exempt from its application but those in group practice are not; and (5) it imposes double licensure requirements on physicians who are pathologists—first they must be licensed by the Board of Medical Examiners as physicians and surgeons, and under S-317 they would have to be licensed again as laboratory directors.

*S-343 —To establish the Aircraft Noise Control Act. *ACTION DEFERRED*, pending further information from the Committee on Environmental Health.

S-451 —To provide for the Local Health Service Act. *APPROVED*

S-460 —To authorize the Commissioner of Health to purchase residential and non-residential care and treatment of drug addicts and abusers in non-State facilities. *APPROVED*

S-464 —To require once a month fire drills in any private hospital, convalescent home, private mental hospital or private nursing home. *APPROVED*

*S-483 —To require all prescriptions for Schedule II substances to conform to requirements as defined in Section 6 of the New Jersey Controlled Dangerous Substances Act. *DISAPPROVED*, because (1) although we support all intelligent and practicable means of controlling drug abuse, the volume of drugs made available to addicts through doctors' prescriptions is minimal, (2) the work entailed in keeping these records would involve quite a bit of time and expense, and (3) because present New Jersey and Federal Legislation are adequate to control this type of drug abuse.

S-508 —To require issuance and renewal of all professional and occupational licenses for a two year period and to provide for staggering expiration dates. *APPROVED*

S-518 —To provide that the act concerning medical service corporations shall not apply to health maintenance organizations which deliver comprehensive health prevention, mainteance and treatment services. *NO ACTION*

S-519 —To permit parole of persons sentenced for drug abuse and in need of treatment provided they obtain admittance to an appropriate treatment facility for in-patient or outpatient treatment. *APPROVED*

S-544 —To transfer all functions, duties and powers exercised by the State Board of Control of the Department of Institutions and Agencies and the Nursing Home Administrator's Licensing Board to the Department of Health. *APPROVED*

S-554 —To appropriate $10,000,000 of State Lottery Fund proceeds for the establishment and maintenance of regional education centers for children with multiple or severe handicaps or both. *APPROVED*

S-558 —To require all law enforcement officers to determine if any person found in an unconscious state is wearing an identification tag indicating he is an epileptic or diabetic. *APPROVED*

S-566 —To provide that State requirement or standards concerning the processing, packaging, storage, distribution or sale of a food or food product for human or domestic animal consumption shall supersede provisions of any county, municipal or health district. *ACTION DEFERRED*, until copies of the bill are available.

SCR-47 —To create a commission to study the operations of the pharmaceutical industry and to evaluate laws pertaining thereto. *ACCEPTED AS INFORMATIONAL*

SJR-1 —To create a commission to study the nature, extent and amount of State aid programs for mentally retarded persons. *ACCEPTED AS INFORMATIONAL*

SJR-7 —To create a commission to devise the most practicable way of establishing a judicial mechanism for dealing with drug addicts and others impaired by their psychological condition. *ACCEPTED AS INFORMATIONAL*

SJR-8 —To create a council to formulate a program for dissemination of public information concerning drugs and drug abuse. *ACCEPTED AS INFORMATIONAL*

A-10 —To repeal P.L. 1971, Chapter 231 thereby creating P.L. 1952, Chapter 230 requiring registration of narcotic addicts with the police. *NO ACTION*

A-16 —To correct a typographical error in P.L. 1966, Chapter 141 concerning content of alcohol in a motor vehicle violation defendant's blood. *APPROVED*

A-21 —To provide that State air pollution codes, rules and regulations may include, in addition to negative restrictions on the emission of pollutants, any affirmative requirements related thereto. *APPROVED*

A-26 —To provide for examination of public school pupils suspected of being under the influence of controlled dangerous substances. *APPROVED*

*A-43 —To repeal the statute making attempted suicide a disorderly persons offense and to provide for hospitalization of such persons by a magistrate or judge of any court. *APPROVED*

A-45 —To require freeholders in counties with facilities for detention of children under 16 years of age to establish tutorial and mental health programs under guidelines to be established by the Commissioner of Institutions and Agencies. *APPROVED*

A-52 —To provide for exhaust emission standards which must be met in inspections of motor vehicles. *ACTION DEFERRED*, pending further information from the Committee on Environmental Health.

*A-57 —To prohibit use of lead paint on toys, furniture and interior of dwellings. *APPROVED*

*A-74 —To include persons who supply indispensable limited medical technical ancillary services under direction of regularly licensed physician under the immunity clause of the Medical Practice Act. *ACTIVE SUPPORT*

A-78 —To create a Rutgers, South Jersey Medical and Dental College Planning Council. *DISAPPROVED*, because although the Society has consistently urged and strongly supported establishment of a third medical school in southern New Jersey as soon as possible, it approved and supported the incorporation of both existing schools—at Newark and Rutgers—under the title of "The College of Medicine and Dentistry of New Jersey" and under the control of one Board of Trustees. We hold that a third school should be under the same corporate title and the same Board's control.

*A-85 —To prohibit water pollution by thermal discharge except under approved conditions. *APPROVED*

A-86 —To license and regulate the practice of collection agencies. *NO ACTION*

A-98 —To make certain conduct by debt collectors a disorderly persons offense. *NO ACTION*

*A-121 —To permit freeholders in counties with no hospital for treatment of children with sickle cell anemia to appropriate not more than $5,000 each for such diagnosis and treatment and not more than $10,000 in first class counties with more than 800,000 population. *APPROVED*

*A-201 —To regulate the sales of medicine containing ethyl alcohol, antihistamines, dextromethorphan, phenobarbital or its salts, ephedrine or its salts or belladonna or any of its alkaloids. *APPROVED*

*A-204 —To appropriate $1,000,000 to the Department of Health for family planning and related services. *NO ACTION*

*A-213 —To provide for origination of proceedings concerning child abuse. *DISAPPROVED,* because there is no dependable logical basis for the presumption that a parent or guardian convicted of "any crime or offense relating to the use, possession, sale, transportation or other dealing in or with narcotic drugs" would be per se guilty of child abuse. Furthermore, some of the individuals granted the right to initiate proceedings under this bill do not possess requisite educational and clinical experience to determine that the resultant injury was not accidental.

*A-237 —To prohibit the littering of waterways and adjacent shores and beaches and to regulate marine toilets and to repeal Chapter 13, P.L. 1954 and Chapter 170, P.L. 1958. *APPROVED*

A-247 —To provide courses in public health in public schools shall include instruction in nutrition and selection and preparation of food for personal and family consumption. *APPROVED*

A-255 —To provide for licensing of hearing aid dispensers by the State Board of Medical Examiners to create a Hearing Aid Dispenser Examining Committee and to provide for violations. *APPROVED*

A-260 —To permit the Board of Medical Examiners to waive any requirements and conditions to be satisfied by applicants for license to practice medicine and surgery if it determines such action would beneficially serve the people of the State. *DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES,* as contrary to public interest, because it would in effect empower the State Board of Medical Examiners to set at naught the objective requirements of the Uniform Medical Practice Act regarding the granting of licenses to practice medicine and surgery in New Jersey, and permit them to grant licenses on the grounds of the purely personal and subjective judgments of Board members, who would be exposed unduly to pressures of all kinds.

A-262 —To appropriate $250,000 to the Department of Health for administration of the Renal Diseases Program. *APPROVED*

A-269 —To increase membership on the State Board of Control of Institutions and Agencies from 9 to 11 members. *NO ACTION*

*A-285 —To provide that the act concerning licensing of physicians shall not apply to a physician or surgeon duly licensed to practice in any foreign country where requirements are not lower than in this State where such person is temporarily teaching in a medical school approved by the Board of Medical Examiners. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

A-297 —To provide that any person, including a minor believing himself a narcotic addict, may be admitted to any State or county institution having special facilities for care and treatment of drug addicts. *APPROVED*

A-303 —To require hearing and eye examination of every motor vehicle applicant and once every six years thereafter. *APPROVED*

A-307 —To direct the acquisition of the Margaret Hague Maternity Hospital for $1 for use of the College of Medicine and Dentistry. *ACTION DEFERRED,* pending reply from the Margaret Hague Maternity Hospital.

*A-315 —To authorize the Commissioner of Institutions and Agencies to establish a program for treatment of rehabilitation of drug addicts who are inmates of correctional institutions and to require freeholders to put such into effect in jails, workhouses, and penitentiaries of their counties. *NO ACTION*

*A-317 —To require motor vehicle license applicants to submit to eye examinations and once every four years thereafter. *DISAPPROVED,* because the Society has approved Assembly Bill No. 303 as a simpler and more practicable measure, particularly since it calls for re-examinations at six instead of four year intervals.

*A-329 —To require written consent of a parent of a pupil prior to administration to him by public school authorities of any drug or medication for experimental purposes or for stimulating the learning process. *APPROVED*

*A-342 —To permit medical assistance to foster children under the supervision of a private nonprofit adoption agency. *APPROVED*

*A-350 —To provide that any applicant for a medical license in addition to supplying required proofs can show that he has been engaged in a reputable practice for 10 years shall be granted a license without further examination upon payment of a fee. *DISAPPROVED,* because it would abrogate the

present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof", "reputable practice", and "conceded eminence and authority in his profession."

*A-351 —To provide for granting an applicant a license to practice medicine and surgery upon proving that he was examined and licensed by the appropriate body of any foreign country. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

A-356 —To permit a person related to one believed to be a narcotic addict to petition the court requesting such person be admitted to a hospital for treatment of his addiction. *APPROVED*

A-359 —To require each district and regional board of education to appoint an advisory committee on narcotics for each high school in its district. *APPROVED*

*A-361 —To authorize the Board of Medical Examiners to grant employees of a municipal hospital who hold M.D. or D.O. degrees an exemption from the licensing requirements of the act concerning licensing of physicians. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

A-365 —To authorize the Department of Institutions and Agencies to purchase residential care and treatment for mental patients in existing non-State facilities. *APPROVED*

*A-394 —To provide for consent by minors to treatment for mental illness. *DISAPPROVED,* because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.

*A-398 —To prescribe that certain publications, listings, or communications shall not be deemed advertising by podiatrists, physicians, surgeons, chiropractors, and psychologists. *ACTIVE SUPPORT*

*A-402 —To provide for licensing, inspection and regulation of maternity homes and similar type facilities and to permit nursing home corporations to operate without requiring stockholders and directors to be residents of the State. *APPROVED*

A-415 —To appropriate $250,000 to the Department of Health for a chronic renal kidney disease program. *APPROVED*

*A-419 —To provide for eye examinations of every child enrolled in the kindergarten class and to permit boards of education to authorize examinations for pupils in other grade levels. *DISAPPROVED,* because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-420 —To establish a program for hemophilia in the Department of Health. *APPROVED*

A-423 —To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED,* because under certain circumstances immunization against rubella is contraindicated.

*A-427 —To permit boards of education to provide sex education for grades 7 through 12. *DISAPPROVED,* because sex programs should not be prohibited for pupils below the 7th grade, provided the programs and teachers are carefully screened and approved and parental approval is given.

A-433 —To provide that the Commissioner of Environmental Protection shall formulate rules and regulations concerning the labeling and prohibiting, conditioning, and controlling the sale of cleaning agents whose use may tend to cause adverse affects on man or the environment. *ACTION DEFERRED,* pending further information from the Committee on Environmental Health.

A-446 —To eliminate the requirement for a post mortem examination where death occurs within 24 hours after admission to a hospital or institution. *ACTION DEFERRED,* until a copy of the bill is available.

A-455 —To include any association created for the purpose of protecting animals under the act concerning the New Jersey Society for the Prevention of Cruelty to Animals. *DISAPPROVED* because there is no evidence that existing statutes protecting dumb animals from cruelty are now being flagrantly violated or that the SPCA has failed—or is failing—to perform its responsibilities in enforcing those statutes.

A-463 —To require all persons riding in the front seat of an automobile manufactured after 1 July 1966 to wear seat safety belts. *DISAPPROVED,* because there are certain medical conditions in which the wearing of seat belts is contraindicated.

A-514 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *ACTION DEFERRED,* pending further information from the New Jersey Society of Pathologists.

A-523 —To require school buses to provide seat belts and protective padding for every seat. *APPROVED*

A-539 —To provide under the Air Pollution Control Act that noise shall be considered an air contaminant and at a level greater than 108 perceived noise decibels shall be a prima facie evidence of air pollution. *ACTION DEFERRED,* pending further information from the Committee on Environmental Health.

A-549 —To require labeling of frozen food that has been thawed. *APPROVED*

A-571 —To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*

A-608 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

ACR-3 —To create a commission to inquire into the condition of the nursing homes and the personal care facilities for the aged. *ACCEPTED AS INFORMATIONAL*

AJR-6 —To designate the week of March 5-11, 1972 as Nurse Education Week. *ACCEPTED AS INFORMATIONAL*

ACR-28—To create a commission to study the use of, sources of and addiction to narcotic and hallucenogenic drugs in colleges, universities and high schools. *ACCEPTED AS INFORMATIONAL*

ACR-31—To reconstitute the legislative commission to study the revision of child abuse laws. *ACCEPTED AS INFORMATIONAL*

3. *Proposed State Legislation* . . . Approved for introduction in the 1972-1973 Legislature a bill on *fluoridation* (to authorize the inclusion in the State Sanitary Code a requirement for the fluoridation of certain public water supplies) and a bill on *limitation of licensure of health care providers* (to require that an applicant for licensure to practice any of the branches of the healing arts shall be eligible only if he is a graduate of a professional college accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the United States Office of Education, DHEW.

Council on Mental Health . . . Approved as amended the report of the February 2nd meeting of the Council on Mental Health, including the following recommendations:

Separate Department of Mental Health

1. That the Board of Trustees convey to Mr. Clifford, the new Commissioner of Institutions and Agencies, MSNJ's desire to arrange a personal meeting with him to discuss the present State mental health system; and

2. That the Board consider the appointment of a special task force to work towards the accomplishment of this end.

Note: The Board directed that the task force be composed of five members, three to be appointed by the President and two to be appointed by the Chairman of the Council on Mental Health.

Public Law 91-616—provides for availability of federal funds for treatment and control of alcoholics.

3. That the Board of Trustees of MSNJ send a letter to Mr. William Chamberlain, Coordinator, Alcoholism Program, New Jersey Department of Health, with copies to Governor Cahill and to the Commissioner of Health, recommending the recognition of alcoholism as a chronic disease and urging:

a. A greater expenditure of State funds for the *detection and* control of alcoholism, since a substantial percentage of all general admissions are estimated to be alcohol-related; (Italics indicate Board amendment)

b. *The need for establishment statewide of alcoholism detection clinics calculated to detect and aid the problem drinker before the development of overt alcoholism;* (Italics indicate Board amendment)

c. The need for the establishment of half-way houses for rehabilitation programs and the involvement of other groups, such as Alcoholics Anonymous, in such programs;

d. The necessity to establish and expand separate alcoholism facilities in each public psychiatric hospital and to insist on after-care clinic affiliations and referrals;

e. That all general hospitals actually admit alcoholics.

Representation at Board Meetings—

4. That the Chairman or his designated representative from the Council on Mental Health be invited to attend meetings of the Board of Trustees at which Council's reports are to be considered.

Eye Health Screening Program . . . Received a report on the results of the 1971 eye health screening program which revealed that 12,181 were screened in 86 centers in New Jersey, showing 5,312 positive results and 520 tonometry suspects—follow-up from the Commission for the Blind indicated 19 positive glaucomas and 7 possible glaucomas.

. . . Approved a recommendation that the Eye Health Screening Program be conducted in 1972 during the week of September 11, 1972.

Committee on Conservation of Vision, Hearing, and Speech . . . Approved the following recommendation from the Committee on Conservation of Vision, Hearing, and Speech:

That MSNJ invite the President and President-Elect of the New Jersey Academy of Ophthalmology and Otolaryngology to serve as Consultants to the Special Committee on Conservation of Vision, Hearing, and Speech.

Environmental Health . . . Approved the following recommendation from the Committee on Environmental Health:

That the Council's (Council on Public Health) budgeted $300 for annual meeting expenses be allotted to the Special Committee on Environmental Health to cover exhibit expenses for the 1972 Annual Meeting.

Immunization . . . Approved the following recommendation from the Council on Public Health:

That MSNJ write a letter to the Public Health Council of the New Jersey Department of Health, approving legislation transferring mandatory immunization to the New Jersey Sanitary Code and making immunization requirements uniform for the local school boards throughout the State.

Council on Public Relations . . . Approved the following recommendation from the Council on Public Relations which resulted from the Council's consideration of Resolutions #7 and #22 from the 1971 House of Delegates concerning the expansion of public relations activities through engagement of outside professional public relations assistance:

1. That the Board of Trustees engage Mr. Edward Meara, of Daniel Edward, Incorporated, to serve in the dual role of Legislative and Public Relations Counsel, on the basis of a monthly retainer plus fee for service compensation for extra assignments; and

2. That his initial engagement be from 1 March through 31 May of this administrative year, with first emphasis to be placed on the improvement of PR activities at the 206th Annual Meeting.

Committee on Publication . . . Approved the report of the January 18 meeting of the Committee on Publication, including the following recommendations:

1. That the advertising rates for full and half-page advertisements in *The Journal*, MSNJ, be increased by 15 per cent, effective as existing contracts expire. (This will not reflect a noticeable increase in income until January 1973, since most advertising contracts were signed as of January 1972.)

2. That the yearly subscription rate for *The Journal* be increased to $7 and that the charge for single copies be increased to $1, effective immediately.

3. That the commission payable to the Advertising Manager for *The Journal*, MSNJ, be increased to 15 per cent of net SMJAB receipts, effective immediately.

4. That The Medical Society of New Jersey accept the price increase requested by Hughes Corporation (7.7 per cent for composition, 8.1 per cent for presswork, and 12.1 per cent for bindery), and that at the end of the present contract MSNJ put the cost of printing *The Journal* out for bids, as was done two years ago, when Hughes proved to be low bidder by a considerable margin.

Emergency Medical Identification . . . Approved a recommendation from the Committee on Emergency Medical Care that MSNJ send a letter to specified agencies, companies, organizations, and the membership stating that The Medical Society of New Jersey, in cooperation with the Division of Emergency Health Services (USPHS) is undertaking a statewide program to inform the citizens of New Jersey of the urgent necessity for *emergency medical identification.* (Franked envelopes will be made available to MSNJ for mailing such a letter, and accompanying literature, by the Division of Emergency Health Services.)

Emergency Telephones on Highways . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That the Board of Trustees of MSNJ recommend to the State Department of Transportation and the New Jersey Bell Telephone Company that emergency telephones be installed on major highways and thoroughfares.

Ad Hoc Committee on Emergency Medical Care . . . Approved the following recommendation from the Committee on Emergency Medical Care:

1. That the Board of Trustees authorize the formation of an *Ad Hoc* Interagency Committee on Emergency Medical Care with the members consisting of a representative and alternate from MSNJ, New Jersey Chapter of the Trauma Committee of the American College of Surgeons, New Jersey State Health Department, New Jersey Chapter of the American College of Emergency Physicians, New Jersey Chapter of the American College of Physicians, *the American Academy of Family Physicians, the New Jersey Orthopaedic*

Society, and the Division of Emergency Health Services, USPHS, Region II. (Italics indicate Board amendment.)

2. That MSNJ, being the parent organization, issue letters to the respective organizations requesting their approval and if all organizations are in agreement, a luncheon meeting be held soon, possibly by 1 March. Expenses of this first meeting and luncheon to be borne from the budget of the Committee on Emergency Medical Care.

Ad Hoc Committee to Evaluate Legislative Solution to Professional Liability . . . Approved the report of the February 6th meeting of the *Ad Hoc* Committee to Evaluate Legislative Solutions to Professional Liability, including the following recommendation:

That the Board of Trustees transmit to the Council on Legislation drafts 1 through 7 (listed below) with the direction that they are to be given equal priority and are proposed for immediate introduction in accordance with the Council's established procedure.

1. An Act imposing a $100,000 limit on the amount which may be awarded in a "medical malpractice action" and defining that term.

2. An Act relating to confidentiality of information and data secured by and in the possession of committees having as their purpose the improvement of the quality of health care services rendered in hospitals and elsewhere.

3. An Act concerning emergency care and amending Section 1 of Chapter 254 of the Laws of 1968 (C. 2A:62A-1).

4. An Act concerning the rendering of emergency care or assistance by physicians or surgeons.

5. An Act concerning malpractice suits and providing for the posting of a bond under certain circumstances.

6. An Act prescribing the time within which actions to recover damages for injuries arising from services rendered by a physician or surgeon shall be instituted.

7. An Act concerning consent to medical and surgical treatment.

Committee on Resolutions . . . Named the following as members of the Committee on Resolutions which was established by the Board of Trustees, upon recommendation of the Committee on Annual Meeting, at its meeting on July 18, 1971: Emanuel M. Satulsky, M.D. (chairman), Nicholas A. Bertha, M.D., and John F. Kustrup, M.D.

Bids for Headquarters Addition . . . Approved a recommendation from the joint meeting of the Executive Committee and Committee on House Maintenance that the lowest bidders for construction of the addition to the headquarters building be awarded the contracts:—General contractor—D. Scott Construction; plumbing and heating—William F. Hindley; electrical contractor—Scott Electrical.

New Jersey Medical Advisory Committee to Selective Service . . . Directed that the following names be forwarded to the Chairman of the National Advisory Committee to the Selective Service System for consideration (until his recent death Dr. Jesse McCall had served as chairman of the New Jersey Medical Advisory Committee): Joseph R. Jehl, M.D., Clifton; John J. Bedrick, M.D., Bayonne; and Isaac N. Patterson, M.D., Westville.

AMA Delegates . . . Noted that with the death of Dr. Jesse McCall the number of AMA Delegates was reduced to our allotted six (see March 1972 issue of *The Journal*, p. 261).

. . . Accepted the resignation of Jerome G. Kaufman, M.D., as AMA Delegate and directed that a letter be sent to him conveying the Society's indebtedness for his many services.

. . . Elected, from the list of Alternate Delegates to the AMA, George L. Benz, M.D. to fill the unexpired term of Dr. Kaufman, and by so doing reduced the number of incumbent AMA Alternate Delegates to six, as required.

Council/Committee Representation at Board Meetings . . . Approved the suggestion, and authorized its implementation, that when a council or committee is submitting a report to the Board of Trustees, the chairman or vice-chairman of that body be invited to attend the Board meeting in order to answer any questions that might arise.

March 19, 1972

Headquarters Addition . . . Concurred in the action of the Executive and House Maintenance Committees that there was no reason to ask the Board of Trustees to reconsider its

action of February 27th (recorded on p. 469) in accepting the recommendation of the aforementioned Committees for awarding contracts for construction of the addition to MSNJ headquarters.

The preceding action resulted from a meeting of these two Committees on March 2, in response to a telegram from the Union County Medical Society registering its opposition to the Board's approval of contracts for such renovations and urging that negotiations cease until the House of Delegates considers the project. The Committees issued to the members of the Board of Trustees and to the County Societies a summary report chronicling the constitutional propriety and development of the project for expansion of the Society's headquarters from its inception at the June 19, 1966 Board meeting to the *unanimous* action of the Board on February 27, 1972.

. . . Approved the report of Legal Counsel that he had reviewed the contracts of D. Scott Construction, William F. Hindley, and Scott Electrical for the expansion of the Executive Offices and found them to be in order.

. . . Directed that the foregoing contracts be executed by the proper officials of the Society.

New Jersey Medical Advisory Committee to Selective Service . . . Directed that the name of Charles L. Cunniff, M.D., be forwarded to the Chairman of the National Advisory Committee to the Selective Service System for consideration as the successor to the late Jesse McCall, M.D., former Chairman of the New Jersey Medical Advisory Committee. The names of the physicians previously nominated by the Board were withdrawn when notification was received that the age limit is 55.

School Placement of Emotionally Ill and Socially Maladjusted Child . . . Approved the report of the Council on Mental Health which contained the following recommendation from the Committee on Emotional Disorders of Childhood and Adolescence:

That the statement on "Placement of the Emotionally Ill and Socially Maladjusted Child in the School System" be submitted to the Editor of *The Journal* for publication. (See page 479, this issue.)

Separate Department of Mental Health . . . Noted that Robert S. Garber, M.D., and Martin H. Weinberg, M.D., had been appointed by the Chairman of the Council on Mental Health as members of the special task force to discuss the present State mental health system with the Commissioner of Institutions and Agencies.

Medical Defense and Insurance . . . Concurred in the action of the Committee on Medical Defense and Insurance in disapproving the issuance of professional liability insurance to Ray-Trex or any other "service corporation." The Committee had had a request from Sharlin Radiological Associates of Hackensack for liability insurance for their subsidiary, Ray-Trex, a service corporation owned by four physicians who practice as a professional corporation. It was noted that there is no requirement prohibiting the transference of Ray-Trex shares to individuals other than physicians, nor is there any limitation on the business activities of Ray-Trex Corporation.

. . . Accepted the resignation of William J. D'Elia, M.D. as a member of the Committee on Medical Defense and Insurance, effective May 6, 1972, and voted to commend him for his service on the Committee in behalf of the Society.

Medical Student Loan . . . Approved the report and following recommendations of the March 1st telephone conference of the Committee on Medical Student Loan Fund, which was held in response to a communication from Mr. Samuel Landis, Chairman of the Medical Opportunities Fund of the College of Medicine and Dentistry of New Jersey, requesting that the Board consider placing a proposal before the House of Delegates for a $10 assessment to provide loan and scholarship funds for needy students, through the abovementioned fund. It was agreed by the Committee that this did not fall within its purview, and that a request for a special assess-

ment could be brought before the House of Delegates by means of a resolution from any component society.

(1) That since the Society already has a Medical Student Loan Fund established and in operation for over fifteen years, detailed information on the Medical Student Loan Fund be supplied to Mr. Landis; and

(2) That if the College of Medicine and Dentistry of New Jersey decides to launch a campaign to establish a separate fund which it would administer and control, MSNJ offer to address envelopes, without expense, to all Society members.

Physicians' Relief Fund . . . Approved, as amended, the report of the February 3rd meeting of the Committee on Physicians' Relief Fund, including the following recommendation:

That the Board of Trustees approve the adoption of the proposed Rules, Manual, and Application Form of the Physicians' Relief Fund.

Note: Copies have been distributed to the County Societies and are on file in the Executive Office.

Project Hope/Vietnam . . . Agreed to adopt the following regulations for future Project Hope/Vietnam fellowships:

1. That normally an individual should apply for the grant before he enters upon the service, but that the actual payment of the grant should be made after the service has been completed. In exceptional circumstances, under which the physician who entered upon the service would suffer financial hardship, prepayment of the grant should be made at the discretion *of the Special Committee on Project Hope and Vietnam, with the concurrence* of the Board of Trustees. (Italics indicate amendment by the Board of Trustees.)

2. That an individual should be eligible to receive the grant only once in any one year.

Academy of Medicine of New Jersey . . . Received a report from Sherman Garrison, M.D., President of the Academy of Medicine of New Jersey, concerning the future plans of the Academy in reference to location and continuing relationships with MSNJ, the CMDNJ, and the various specialty societies, and commended him for his effective leadership of the Academy.

Conference of Presidents of Component Societies . . . Met with 28 representatives of 19 component societies and discussed the following items of significance: (1) a physicians' union, (2) current status of HMO's in New York, (3) revisions in Medical Practice Act, (4) the purpose of associate membership—to serve a probationary period, (5) delegates to MSNJ House—do not have to be members of the AMA, (6) medical-legal agreements between county medical societies and county bar associations, (7) comprehensive health planning—Mr. Joseph Kale, Acting Director of Comprehensive Planning, addressed the meeting, answered questions, and distributed informational material, (8) liability insurance, (9) difficulties in providing appropriate institutional care for medical patients in view of denials of payment for such care, (10) a director for the Division of Drug Control in the Department of Health, (11) phase II of the economic regulations, (12) peer review, (13) premarital examinations, (14) credential procedures to permit applicants to be aware of their acceptance or rejection to membership within four months of application, (15) establishment of an educational program for the foundation of HMO's in New Jersey, (16) podiatrists as part of team physicians for athletes, (17) adequate representation in the legislature, and (18) insurance company requirement for mandatory consultations for patients.

National Health Service Corps in Newark . . . Voted provisional approval of a plan of action for the implementation of the National Health Services Corps in Newark, under the Emergency Health Personnel Act of 1970. This provisional approval is to become full approval if (as is anticipated) Essex County votes formal approval.

Ad Hoc Committee on Foundation Planning . . . Approved the establishment of an Ad Hoc Committee to Study and Make Recommendations Concerning the Foundation Approach to Medical Care and named the following physicians to serve on the Committee:

Richard F. Lang, M.D., Passaic, Chairman
Louis F. Albright, M.D., Spring Lake
George L. Benz, M.D., Newark
William J. D'Elia, M.D., Neptune City
James S. Todd, M.D., Ridgewood

Ad Hoc Committee for Selection of Nominees for AMA Councils and Committees . . . Authorized the establishment of an Ad Hoc Com-

mittee for Selection of Nominees for AMA Councils and Committees and named the following members:

1st District—Henry J. Mineur, M.D., Cranford
2nd District—Vincent H. Gillson, M.D., Teaneck
3rd District—William H. Coleman, M.D., Trenton
4th District—Harold L. Colburn, Jr., M.D., Moorestown
5th District—Nicholas E. Marchione, M.D., Vineland
President (E. Vernon Davis, M.D., Mount Holly), Ex-Officio
Chairman, New Jersey Delegation to the AMA (Joseph P. Donnelly, M.D., Newark), Ex-Officio

Note: Doctors Davis and Donnelly are serving as ex-officio members by virtue of their respective offices.

Attendance of AMA Delegates . . . Agreed to rescind its previous policy dealing with MSNJ representation at AMA annual and clinical conventions and to authorize the attendance of all delegates and alternate delegates at future meetings.

. . . Authorized the following to attend the AMA Annual Convention June 18 to 22, 1972 in San Francisco and the AMA Clinical Convention November 26 to 29, 1972 in Cincinnati, with a per diem allowance of $50: President, President-Elect, Executive Director, six regular delegates and six alternate delegates.

Jersey City Medical Center—Application under Emergency Health Personnel Act of 1970 . . . Voted (on the basis of information provided by the President of the Hudson County Medical Society that there is no shortage of physicians in Hudson County, particularly in Jersey City) to disapprove the request of the Jersey City Medical Center for assignment, under the Emergency Health Personnel Act of 1970, of corps personnel in their emergency room.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during March 1972:

	1972 March	1971 March
Aseptic meningitis	6	10
Encephalitis	5	1
Primary	2	1
Post Infectious	3	0
Hepatitis: Total	428	317
Infectious	325	255
Serum	103	62
Malaria: Total	1	8
Military	0	7
Civilian	0	1
Meningococcal meningitis	6	11
Mumps	160	289
German measles	95	72
Measles	150	139
Salmonella	88	27
Shigella	37	20

Gonorrhea

The U.S. Public Health Service announces recommendations for the treatment of gonorrhea. These were established because of the slowly increasing resistance of the gonococcus to antibiotics. It is hoped that these rather large doses will be successful in treating almost all persons with uncomplicated gonorrhea and prevent the development of further antibiotic resistance.

Recommended Treatment Schedules—March 1972—For *Neisseria gonorrhoeae* infection the preferred drug is penicillin or ampicillin. Physicians are cautioned to use no less than the recommended doses of antibiotics.

For Treatment of Uncomplicated Gonorrhea (Urethral, Cervical, Pharyngeal, or Rectal)—

Parenteral (Men or Women)—Aqueous procaine penicillin G, 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 Gram of oral probenecid, preferably given at least 30 minutes prior to the injection, or

Oral (Men or Women)—Ampicillin, 3.5 Grams, with probenecid, 1 Gram, administered simultaneously.

Treatment of Contacts—Patients with known exposure to gonorrhea should receive the same treatment as those known to have gonorrhea.

When Penicillin or Ampicillin is Contraindicated, or When the Above Schedules are Ineffective—(allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction).

Parenteral (Men)—Spectinomycin, 2 Grams, in one intramuscular injection, (Women)—

Spectinomycin, 4 Grams, in one intramuscular injection, or

Oral (Men or Women)—Tetracycline HCl, 1.5 Grams initially, followed by 0.5 Gram four times a day for four days, a total dosage of 9 Grams. Other tetracyclines are not more effective.

Follow-up—Follow-up urethral cultures should be obtained from males seven days after completion of treatment; cervical and rectal cultures should be obtained from females at seven to fourteen days after completion of treatment.

Complications—Although treatment of complications (gonococcal salpingitis, bacteremia, arthritis, and so/on) must be individualized, repeated large parenteral doses of aqueous crystalline penicillin G have been shown to be effective. The efficacy of alternate antibiotic regimens is unproved. Post-gonococcal urethritis can be treated with tetracycline, 0.5 Gram, orally four times a day for at least seven days.

Syphilis—All gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients receiving the recommended parenteral penicillin schedule need not have follow-up serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a follow-up serologic test for syphilis each month for four months to detect syphilis that may have been masked by treatment for gonorrhea.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

While long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *NO* place in the treatment of gonorrhea.

Patronize Our Advertisers

Medical Women's Notes

The New Jersey branch of the American Medical Women's Association submitted the following resolutions to the parent organization in December 1971:

1. AMWA resolves to encourage and support legislation which would institute more stringent controls over proprietary drug advertisements in public media.

2. AMWA resolves to accept all qualified members regardless of race or creed.

3. AMWA resolves that branch membership be requisite for all national members.

4. AMWA resolves that a rapid pregnancy test be performed prior to x-ray examination on all women of child-bearing age.

Dr. Christine Haycock, Assistant Professor of Surgery at the College of Medicine and Dentistry of New Jersey, and full Colonel, United States Army Reserves, received the Outstanding Alumna Award (1971) from Bloomfield College and was interviewed in conjunction with the award on Station WFMU from Rutgers, discussing "Roadblocks for Women in Surgery."

MD Responsibility for Reporting Battered Children

Senate Bill 747 has been signed by the Governor and is now law. This makes it mandatory for the physician to report to the prosecutor the case of any child (under age 18) where the doctor "has reasonable cause to suspect that the child has had serious injury inflicted upon him by other than accidental means, or whose condition gives indication of abuse or maltreatment." If the child is in an institution, the report may be made "to the person in charge of the institution." The act imposes penalties for "willfully failing to make the report" and it also immunizes the doctor from legal liability for making such a report.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinamycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials cantaining 5 ml when reconstituted with diluent. 4 gm vials cantaining 10 ml when reconstituted with diluent.
An aminocyclital antibiotic active *in vitro* against most strains of *Neisseria ganarrhaeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitra* studies have shown no cross resistance af *N. ganarrhaeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and ocute gonorrheal cervicitis and practitis in the female when due to susceptible strains of *N. ganarrhaeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treotment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask delay the symptoms af incuboting syphilis. Patients should carefully exomined and monthly serolagical follow-up for least 3 months should be instituted if the diagnosis of syphilis suspected.

Safety far use in infants, children and pregnant wamen has n been established.

Precautions: The usual precautions should be observed w atopic individuals. Clinical effectiveness should be monitored detect evidence of develapment af resistance of *N. gonarrhaeae*

Adverse reactions: The following reactions were observ during the single-dose clinical trials: soreness at the injection si urticaria, dizziness, nauseo, chills, fever ond insamnia.
During multiple-dose subchronic tolerance studies in norm humon valunteers, the following were noted: a decrease in hem

Trobicin®

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single-dose intramuscular treatment

High cure rate:* 96% of 571 males, 95% of 294 females
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included.

A72 1048 0

globin; hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
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1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.



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Placement of the "Emotionally Ill" and "Socially Maladjusted" Child in the School System

To aid physicians in counseling parents of mentally and emotionally ill children, the Special Committee on Emotional Disorders of Childhood and Adolescence presents the following information.

The regulations of the New Jersey Department of Education *require* each local school district to identify all children not suitable for regular class placement and to provide placement for these children in special classes suitable to their needs. These regulations require that each district have a Child Study Team basically consisting of a psychologist, social worker, and learning disability specialist. The basic Child Study Team examines children referred to them by the schools, classifies them, and prescribes a program of instruction.

Among the types of children to be so placed are those classified as "emotionally disturbed" and as "socially maladjusted." Classification of these children and recommendations for educational programs are made by the psychiatrist trained or experienced in working with children and/or by the school physician. If the district does not have such special education classes, it must place the child in a suitable class outside the district and provide transportation for the child to the class. A current list of eligible non-public schools and public schools which provide such classes can be obtained by writing to:

Paul Parado, Director
Special Education Program Development
Division of Curriculum and Instruction
New Jersey Department of Education
225 West State Street
Trenton, New Jersey 08625

If a parent feels that his child is placed inappropriately in a regular class and/or needs a special program, the parent should be advised to take his concern to the child's teacher. Should the parent feel that he did not obtain a satisfactory response, he may appeal in through the following in the order listed.

(1) Local Level
  (a) Guidance Counselor
  (b) Local Child Study Team
  (c) Principal

(2) State Level
  (a) County Child Study Team Supervisor
    (c/o County Superintendent of Schools)
  (b) Area Coordinator for Special Education
  (c) Daniel Ringelheim, Ph.D.
    Deputy Assistant Commissioner
    Special Education and Pupil Personnel Services
    New Jersey Department of Education
    Trenton, New Jersey 08625
  (d) Carl L. Marburger, Ph.D.
    Commissioner of Education
    New Jersey Department of Education
    Trenton, New Jersey 08625

Experience has shown that bypassing local school personnel with a complaint is undesirable. It is especially important to obtain the cooperation of the principal in these matters.

The Committee recognizes that there may be some variation in procedures from one locality to the next, as well as variation in interest and cooperation by local school personnel. However, it has been assured by officials of the State Department of Education of their interest in cooperating with physicians in these matters and of their determination that the letter and spirit of the regulations be followed.

The Committee also recognizes the importance of physicians' involvement in the work of the Child Study Team and is concerned about the lack of meaningful involvement of school physicians and psychiatrists in the work of these teams in many localities.

A parallel course of action is available to the parents of children impaired physically or mentally by other causes, who require other types of special class placement (such as, for the blind, deaf, etc.).

ANNOUNCEMENTS

Seminar for Emergency Physicians

An all-day meeting for emergency physicians (9 a.m. to 5 p.m.) has been scheduled for Wednesday, May 17, at the Governor Morris Inn in Morristown. Topics to be covered include pediatric emergencies, cardiopulmonary resuscitation, emergency problems in blood gases, and chest injuries. The $20 fee covers parking, coffee break, luncheon, banquet, and a copy of the printed proceedings of the entire colloquium. For more details, please write to Dr. Herbert P. MacNeal, 7 Wyndmoor Drive, Convent Station, New Jersey 07961.

Symposium on Learning Disabilities

May 19, 20, and 21, 1972 have been set aside for a practical symposium on children with learning disabilities. The colloquium takes place at the Rutgers Medical School in Piscataway. The tuition fee of $75 includes luncheons. The program covers classification, pediatric assessment, psychiatric and psychological evaluation, educational problems, assessment of hearing, speech, and social relationships, functional and organic factors, therapy, and several round table workshops. For a full faculty list and detailed program, write to Dr. Sheldon N. Feinberg, 98 Broadway, Hillsdale, New Jersey 07642. The agencies sponsoring this course are the State Department of Education, the American Academy of Pediatrics, the Association for Children with Learning Disabilities, and Rutgers Medical School.

Psychopharmacology and the Aging Patient

An unusual conference on the use of psychoactive drugs among the elderly will be held May 29, 30, and 31, at the Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina. For further information, please write to Mrs. Dorothy Heyman, Box 3003, Duke University Medical Center, Durham, North Carolina 27710.

Symposium on Computer-Aided Diagnosis

An all-day (9 to 5:30) symposium on computer-aided diagnosis will be held on Wednesday, May 31, at The Center (150 Bleeker Street, Newark) of the Newark College of Engineering. The program, which is designed to stimulate dialogue between physicians and engineers concerning the application of computers in diagnoses, is cosponsored by the Institute of Electrical and Electronics Engineers, MSNJ, the Newark College of Engineering, and CMDNJN. Advance registration is $25 and includes luncheon. Please make your check payable to "NTSAC" and mail to Dr. Kenneth Sohn, Newark College of Engineering, 323 High Street, Newark 07102.

Symposium on Crippled Children

The Intercounty Orthopaedic Association announces an all-day meeting at the State Hospital for Crippled Children in Elizabethtown, Pennsylvania, on Saturday, October 7. Guest speakers include Albert Ferguson, Jr., M.D. —Dislocated Hip in Children; J. Leonard Goldner, M.D.—Congenital Hand Deformities and Club Feet in Children; and Anthony Bianco, M.D.—Spondylolisthesis and Femoral Fractures in Children. For further information, please write to Jerome M. Cotler, M.D., 193 West Commerce Street, Bridgeton, New Jersey 08302.

Medical Hypnosis Courses

Columbia University announces a basic course in medical hypnosis September 30 through November 18, 1972, to be held on Saturdays 10 a.m. to 5 p.m. Tuition is $175. Also available is a course in "Hypnosis and Psychiatry" on Saturdays, 10 a.m. to 5 p.m., January 6 through January 27, 1973. Fee is $100. For more details, write to the Associate Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 10032.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

May

11 **Burlington County Memorial Hospital**
Mount Holly
Zollinger-Ellison Syndrome

11 **Fair Oaks Hospital**
Summit
Brain Tumors

16 **Associated Eye Residencies of New Jersey**
Eye Institute of New Jersey, Newark
Proper Eye Charts and Determination of Visual Acuity

17 **Bergen Pines County Hospital**
Paramus
Malabsorption Syndrome

17 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Surgery for Coronary Artery Disease

17 **New Jersey Committee on Trauma, American College of Surgeons; American College of Emergency Physicians; New Jersey Hospital Associates; USPHS**
Governor Morris Inn, Morristown
Seminar for Emergency Department Physicians

18 **Burlington County Memorial Hospital**
Mount Holly
Drug Interactions

18 **Academy of Medicine of New Jersey**
Mayfair Farms, West Orange
Annual Awards Dinner

24 **Bergen Pines County Hospital**
Paramus
Immunoglobulin Disorders

24 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building, Newark
Colon and Rectal Carcinoma

24 **Essex County Medical Society and New Jersey Commission for Blind**
Eye Institute, Newark
Detecting Glaucoma

25 **Burlington County Memorial Hospital**
Mount Holly
Anticoagulants and Fibrinolytic Agents

25 **Academy of Medicine of New Jersey and Radiological Society of New Jersey**
Hospital Center at Orange
Interesting x-rays of the Month

25 **Fair Oaks Hospital**
Summit
Medical Aspects of Drug Abuse

31 **Bergen Pines County Hospital**
Paramus
Emphysema

31 **Academy of Medicine of New Jersey and United Hospitals of Newark**
Annex Building Newark
Courtroom Confrontation
(A Geigy Film)

June

7 **Bergen Pines County Hospital**
Paramus
Surgery in Coronary Artery Disease

7 **Essex County Medical Society and New Jersey Commission for Blind**
Eye Institute, Newark
Eye Problems in Pediatrics

8 **Fair Oaks Hospital**
Summit
Psychiatric Sociology

14 **Bergen Pines County Hospital**
Paramus
Resident Staff Program

21 **Bergen Pines County Hospital**
Paramus
House Staff Graduation

22 **Fair Oaks Hospital**
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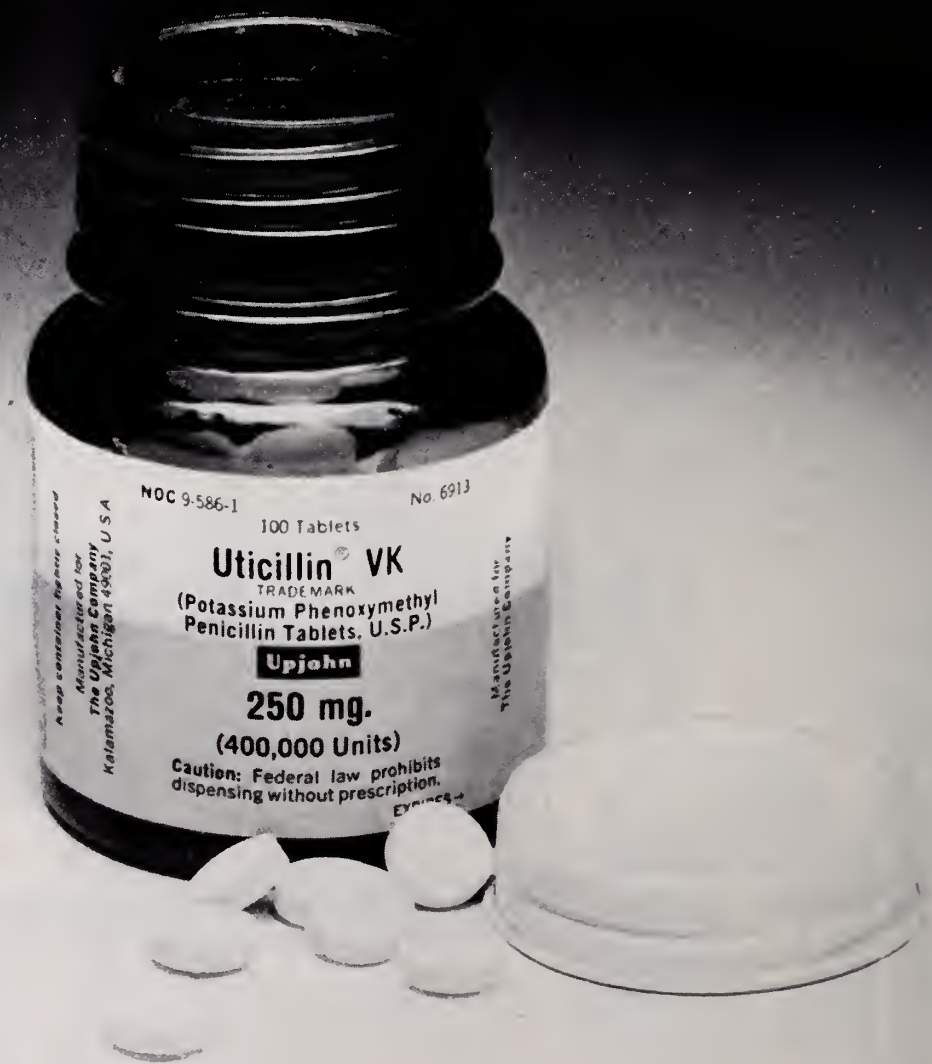
SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. REFERENCES: 1. *Parsons, W B Jr. — Interview Med Trib. Nov. 28-29, 1964.* 2. *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No 14 P. 1563*

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LETTER TO THE JOURNAL

Pain in Methadone Patients

March 1, 1972

Dear Sir:

Methotrimeprazine (Levoprome®—Lederle) is a strong analgesic which belongs chemically to the phenothiazine, rather than the opiate, family.

On theoretical grounds it, therefore, should be fully effective in methadone maintenance of patients who may have developed tolerance to analgesics of the opiate family, rendering opiates rather ineffectual in instances of severe pain.

Use of this drug requires knowledge of its dangers and side reactions. Special emphasis has to be placed on its tendency to produce pronounced postural hypotension as well as marked sedation. *It should not be used on ambulatory patients.* It is also important to know that hypotension produced by its use cannot be counteracted by epinephrine or similar drugs. Epinephrine might even have a paradoxical effect and produce an increase in hypotension. The drug of choice to counteract hypotension occurring in connection with Levoprome® is a vasopressor such as levarterenol bitartrate (Levophed®—Winthrop). This drug comes in ampules of 4 milliliters each. For details of dosage and administration see instructions by Winthrop.

Levoprome® is supplied in an injectable solution in vials, containing 20 milligrams per milliliter. For further details see the American Medical Association's Drug Evaluations, First Edition, Pages N-128 to N-130 and the Physician's Desk Reference.

(signed) Hans W. Freymuth, M.D.

Widows and Orphans Society

Support the Society for Relief of Widows and Orphans of Medical Men of New Jersey. Write to P.O. Box 95, Belleville, New Jersey, for information.

OBITUARIES

Dr. Kenneth Brown

One of central New Jersey's leading obstetricians died on February 29, 1972. With the death that day of Kenneth G. Brown, M.D., Monmouth County lost a man who had been chief of obstetrics at the Jersey Shore Medical Center from 1936 to 1959. He was a member of the Board of Directors of that hospital for 28 years. Dr. Brown, who was 76 years old at the time of his death, was a 1920 alumnus of the Medical School of the University of Vermont. He was active in the affairs of the Monmouth County Medical Society, and was a 1970 laureate of the MSNJ Golden Merit Award.

Dr. Jerome G. Kaufman*

One of our state's most prominent physicians, Jerome G. Kaufman, M.D., died on April 1, 1972. Born in 1901, he was a Harvard graduate who earned his M.D. at Bellevue in 1925. He was a well-known internist, Vice-president of the American Heart Association, and board

*For editorial comment on Dr. Kaufman's death, see page 411 of this issue.

certified in internal medicine. He held professorial status at the New York Medical College. He was the laureate of the Edward J. Ill Award for 1964. For more than a decade, Dr. Kaufman was a trustee of The Medical Society of New Jersey. He served in all presidential chairs, and was President of The Medical Society of New Jersey in 1963-64. Dr. Kaufman was a member, and for several terms, Chairman of our Annual Meeting Committee. He was one of our delegates to the AMA. He was devoted to his work on the State Board of Medical Examiners, and had a term of service as President of that Board. He was an extraordinarily well-rounded medical citizen. He had served as President of the Essex County Medical Society before assuming statewide office.

Dr. Richard J. Lempke

Richard J. Lempke, M.D., a 1944 Jefferson graduate, died on March 5, 1972, at the age of 54. He was an internist, active in Passaic County Medical affairs, and was particularly identified with the American Diabetes Association. Another of his major interests was in life insurance medicine—he was a member of the American Association of Life Insurance Medical Directors.

Dr. Irving K. Perlmutter

At the untimely age of 57, Irving K. Perlmutter, M.D., died on February 9, 1972. A well-known Essex County gynecologist and obstetrician, he was board-certified in both phases of his specialty. He was a 1939 alumnus of the Jefferson Medical College, and a Major in the Medical Corps of the Army from 1940 to 1946. Dr. Perlmutter was affiliated with both St. Barnabas Hospital in Livingston and the Beth Israel Hospital in Newark. He was a Fellow of the New Jersey Academy of Medicine.

Dr. Carlos A. Pons

One of our state's best-known pathologists, Carlos A. Pons, M.D., died on March 9, 1972. He was a member of our Ocean County Medical Society. Born in Puerto Rico in 1896, he came to the continental United States in 1916, and in 1920 he received his M.D. from the Jefferson Medical College. He taught pathology and hematology at Loyola University in Chicago before coming to Philadelphia where he served as clinical pathologist at Blockley. He then came to New Jersey and was chief of pathology at the Shore Memorial Hospital. He was board certified in his specialty.

Dr. Max Strauss

Word has just come of the death, in Forest Hills, New York, of Max Strauss, M.D., who had maintained his membership in our Essex County Component Society in spite of his having moved to New York State on his retirement from active practice in 1957. Dr. Strauss was 95 years old at the time of death, having been born in Germany in 1877. He was a graduate of the Medical School of the University of Munich in 1902 and practiced in Newark for many years. He was on the staff at both Beth Israel (in Newark) and St. Barnabas (in Livingston) prior to his retirement.

Dr. William Tomkins

At the grand age of 85, William Tomkins, M.D., died on March 5, 1972. He was graduated at the age of 23 from Cornell University Medical School, class of 1908. He served the people of Passaic and Bergen Counties for half a century, and had been on the staff of the Valley Hospital in Ridgewood. Dr. Tompkins retired from active practice in 1967, and was living at his old home in Ridgewood at the time of his death. He was the recipient of MSNJ's Golden Merit Award in 1958.

Dr. Rahim Vakili

His many friends were shocked to learn of the death, on January 3, 1972, of Rahim Vakili, M.D., at the untimely age of 39. An Iranian, he was graduated from the Medical School at Tabriz in his native country, earning his M.D. degree in 1959. He came to Boonton, where he practiced obstetrics and gynecology, and was on the staffs of Riverside Hospital in Boonton and St. Clare's in Denville.

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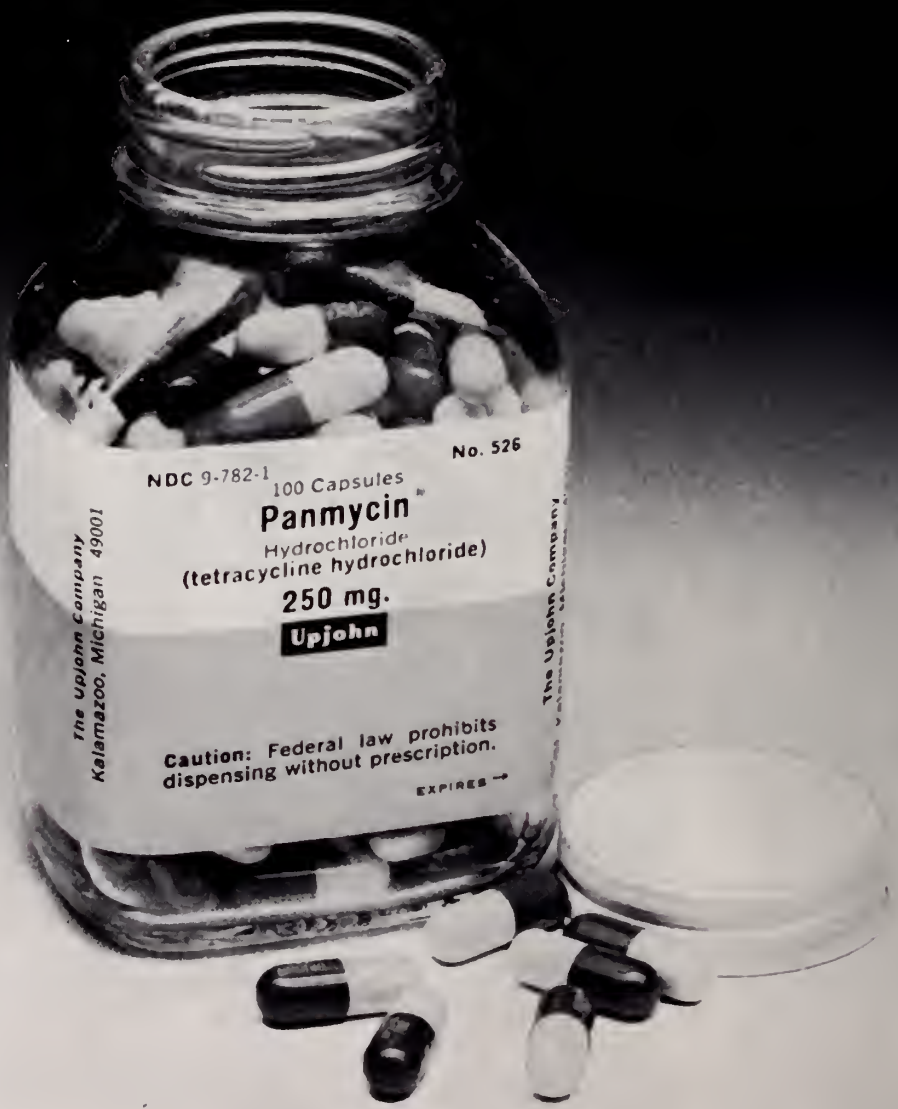
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BOOK REVIEWS

Operative Orthopedics in Cerebral Palsy. Sidney Keats, M.D. Springfield, Illinois, Thomas, 1970. Pp. 243. ($13)

This monograph contains a good deal of useful information for anyone concerned with the cerebral palsy patient. The discussion emphasizes the careful analysis and selection of cases for surgery, as well as the over-all management, of which surgery is but a part. Dr. Keats gives us the benefit of extensive personal experience with these problems.

More careful editing and organization would have made the material easier to locate. Line drawings of the principles of the procedures would be helpful to readers. The review of the literature is excellent, and good references are provided. There is a section on neurosurgical treatment by Blaine S. Nashold, M.D. Dr. J. Leonard Goldner describes procedures used in the upper extremity.

The volume is recommended to all who deal with cerebral palsy.

Daniel J. O'Regan, M.D.

The Skyjacker. David G. Hubbard, M.D. New York, MacMillan, 1971. Pp. 262. ($5.95)

On the basis of his own psychiatric studies of a number of airline hijackers (Dr. Hubbard prefers to call them "skyjackers"), the author has drawn an emotional profile of the men who typically had violent or alcoholic fathers and religiously fanatical mothers. Hubbard also attaches importance to the physiology of the semi-circular canals, suggesting that this is a factor in their indulging in flights of fantasy while in the air.

Infancy is seen as a struggle against the forces of gravity so that the desire to go up in the air and the feeling of freedom there is a primitive unconscious force with deep interpersonal roots. Hubbard's calendar of hijacking suggests that a time relationship exists between news of space events and the frequency of skyjacking.

Some of the psychodynamic explanation may be a bit too theoretical for nonpsychiatric physicians, but Hubbard presents his thesis well, gives good support for his doctrine, and offers some stimulating reading.

Abraham Leff, M.D.

Handbook of Poisoning. Robert H. Dreisbach. Los Altos, California, Lange Publications, 1971. Pp. 515. ($6)

This little giant of information belongs in every hospital emergency room, at every first aid station, and near the telephone of every physician. The book is small and compact with data from cover to cover. It has gone through seven editions, attesting to its acceptance by the profession, and is now also available in a Spanish language edition.

The poisons have been organized into industrial, agricultural, household, medicinal, and natural hazards. These are described briefly, with clinical findings, treatments, and prognosis. Each chapter has short references for further study.

Of particular interest is the chapter on drugs prescribed so frequently, classified as the phenothiazines, the psychic depressants, and stimulants. The side reactions of many of these drugs are long and varied, ranging from deep depressions to violent convulsions. For example, the convulsions and opisthotonic picture of trifluoperazine (Stelazine®) overdosage is similar to strychnine poisoning. The antidote here is diphenhydramine (Benadryl®) I.V.

First aid measures are outlined on the inside front and back covers, for fast reference. Charts are used freely to cover many similar type compounds, their effects and treatment. The book includes "Call Poison Information Centers" all over the United States. In our New York-New Jersey area, the number is (212) 340-4494.

Harry M. Poppick, M.D.

The Surgical Control of Behavior. Arthur Winter, M.D., Editor. Springfield, Illinois, Charles C. Thomas, 1971. Pp. 90. (Price not stated)

Under the aegis of the Academy of Medicine of New Jersey, a seminar was held in April 1970 on the surgical control of behavior. It is here published in a slim, hard-backed edition, edited by Arthur Winter, M.D., a member of the Essex County Medical Society. The topic is an inherently fascinating one: the ancient idea that somehow we can cut the badness out of an individual. The idea is not as childish as this sounds.

The colloquium opens with a paper by Mary A. Brazier, Ph.D., on the neurologic basis for surgery for the relief of temporal lobe epilepsy. Robert Heath, M.D., follows with material which suggests a neurophysiologic basis for schizophrenia and for the creation of pleasure-experiencing sensations through a surgical approach to some areas in the central nervous system. Some interesting possibilities are here suggested in the management of addicts, considered as people who are basically impoverished in their ability to experience pleasure. William B. Scoville, M.D., offers material on the clinical application of neurosurgical technics to modify the psyche and behavior of man. He feels that neurosurgery "can dramatically relieve the symptoms of emotional turbulence and anxiety." This kind of surgery, he suggests, can often "bury hallucinations and delusions" and give "excellent results in anxiety-tension states." Dr. Scoville says that "different types of mental disease do not require different areas of ablation."

The symposium concluded with a paper by Dr. Winter and Leo Shatin, Ph.D., on psychological assessment of patients for neurosurgery, and on evaluation of the results. Interspersed in the book are several sections of comment and discussion based on questions from the audience. Several illustrations are provided showing the anatomy or surgical technics involved. Included in the volume is a brief paper by Humphrey Osmond, M.D., on "personal recollections of lobotomy" which suggests that modern surgical technics make possible more refined methods than were available in the early days of lobotomy.

Hoffmann LaRoche gave acknowledged support to this seminar.

Henry A. Davidson, M.D.

Approach to the Medical Care of the Sick Newborn. Sophie H. Pierog, M.D. and Angelo Ferrara, M.D. Saint Louis, Mosby, 1971. Pp. 292. Illustrated. (Price not given)

This short volume is exactly what it purports to be. It is a survey. It is a beautiful outline and offers a beautiful summary. It is the first place and the best place I know to look when confronted with a newborn in trouble. The book is, however, frustrating. One wishes the authors had given just a bit more information at every level. Many sections are short of references. Thus, there are only five references in the section on infants with a heart murmur.

One of the problems any textbook author faces is keeping up with recent advances. In the main these authors have done a superb job. I was disappointed at not finding more on Gluck's work relative to predicting which babies are likely to develop the respiratory distress syndrome. The authors are cautious about recommending Gentamycin for neonates. I suspect that the evidence now available indicates that this drug is safe in the appropriate situation.

Certainly this is an excellent book for students, interns, and residents. It is remarkably up-to-date and is recommended to old practicing pediatricians who may need refreshment.

Solomon J. Cohen, M.D.

Synopsis of Ophthalmology (Third Edition). William H. Havener. St. Louis, Mosby, 1971. Pp. 553. Illustrated ($12.75)

This book is written in a folksy, conversational fashion that makes for ease of reading and understanding. I find this especially useful in the sections on eye examinations and interpretations of ophthalmologic findings. In the more didactic areas of the text this style becomes less successful.

A large section on applied ophthalmologic technic, with multiple questions after each small section of material, filled one seventh of the book, but did not give full measure for this high proportion of space.

I would recommend this book as a first text for the medical student's introduction to ophthalmology, but I feel it is not comprehensive enough for the beginning ophthalmologist resident or the general practitioner.

Arthur S. Kern, M.D.

Nosocomial Infections: International Conference. Chicago, American Hospital Association, 1971. Pp. 334. ($1.50)

This book includes papers presented at the International Conference on Nosocomial Infections held in Atlanta in August 1971. Many national and international authorities on infectious diseases presented papers at this session. These papers dealt with identifying the types of pathogens currently responsible for hospital-acquired infections, factors relating to host-resistance and host-susceptibility, with discussions of means of prevention of dissemination of infection in hospitalized patients. Some idea of the magnitude of the problem may be gleaned from the figures that in 1967 post-operative wound infections were estimated to result in patient costs of $9.83 billion in this country alone. Problems involving patient infection with indwelling urinary catheters and respiratory therapy equipment are fully discussed. Of interest was a paper dealing with the various pathogenic bacteria in medicinal tablets found in Sweden, including barbiturates, digitalis preparations, and tranquilizers. In 1966, in Sweden, an outbreak of salmonellosis was attributed to ingestion of contaminated thyroid tablets. The concluding discussion in the book is entitled "Nosocomial Infections and the Law," which was presented by Mr Crawford Morris. It is an excellent dissertation on the legal implications of hospital-acquired infections and how the practitioner and hospital may be implicated as responsible for such infections.

This book is recommended as an excellent source of information for those interested in this important topic and would seem to be an invaluable reference work for hospital infectious disease committees.

Henry A. Davidson, M.D.

Christiaan Barnard: One Life. Christiaan Barnard and Curtis Bill Pepper. New York, Bantam Books, 1971 (First published in 1970 by MacMillan). Pp. 529. (Paperback, $1.50)

The main theme in this book is the enormous personal drive in Dr. Barnard to achieve big things and be on top of the heap. He likes being first.

He relates a dramatic story in which he rises from a child in South Africa with limited financial resources to become an internationally known surgeon. His pursuit of excellence, supported by his enormous personal energy to achieve, results finally in his being the first to transplant a human heart. The recollections of Dr. Barnard's training and his family life are well done. The personality studies of people associated with the first heart transplant are most engaging and the presentation is quite unusual.

This is a well-told story with much excitement and interest and will engage most readers. This book is in an attractive paperback and the print is sharp and on appropriate paper.

Robert K. Spiro, M.D.

Biologic Rhythms in Human and Animal Physiology. G. G. Luce. New York, Dover Press, 1971. Pp. 183. (Softback—$2.50)

The human animal—indeed all animals and plants—show fluctuations that accord with the time cycle. The 24-hour cycle, presumably due to diurnal variations in light and darkness is the best known of the rhythms. This is called *circadian* (meaning "about a day"). But some of the rhythmic patterns fluctuate with the month and there are other time-keepers among living things. This book, based on a National Institute of Mental Health survey, reviews the rhythmic patterns in sleep, sensory perceptions, eating, sexual interests, tissue repair, hormone tides, pain tolerance, working and energy patterns, urinary production, responsiveness to drugs, and dozens of other time-bound factors.

The text is documented by over 600 references to the scientific literature, and in spite of its imaginative quality, it is essentially a fact-packed volume on a little understood subject. It makes interesting reading for all of us. We physicians who are supposed to have some expertise in understanding human physiology will find much to think about in this unusual presentation.

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Usage In Children Not recommended for use in children under 12 years of age.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acu hyperexcited states, anxiety, hallu tions, increased muscle spasticity insomnia, rage, sleep disturbance stimulation have been reported; s these occur, discontinue drug. Isc reports of neutropenia, jaundice; periodic blood counts and liver fu tests advisable during long-term t

Dosage: Individualize for ma beneficial effect. *Adults:* Tension, and psychoneurotic states, 2 to 1 b.i.d. to q.i.d.; alcoholism, 10 mg or q.i.d. in first 24 hours, then 5 r or q.i.d. as needed; adjunctively i skeletal muscle spasm, 2 to 10 m or q.i.d.; adjunctively in convulsi orders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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OF THE MEDICAL SOCIETY OF NEW JERSEY

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JUNE 1972
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•

Rising health-care costs, whatever their causes, are the principal argument of the proponents of government-controlled national health insurance.

One controllable item in these rising costs is unnecessary utilization of services. If this were eliminated, escalation of costs would be greatly retarded.

ITEM: A recent on-site survey of one floor by the Utilization Review Committee of the staff of a North Jersey hospital with 92% bed occupancy indicated that 10% of the patients should not have been there at that time. They had been admitted for diagnostic workups which could have been done on an ambulatory basis, and custodial care.

ITEM: The New Jersey Blue Cross Pre-Admission Testing Program (PAT), where it has been actively utilized, has shown average savings of 1.3 hospital days per admission. Last year over 300,000 hospital admissions under age 65 were covered by Blue Cross in New Jersey.

ITEM: Although 71 New Jersey hospitals have signed up for PAT, it is not being utilized to the fullest extent in many of them.

Of course, PAT is not applicable to every type of admission. But if all hospitals used PAT actively, and unnecessary hospital utilization such as that cited in the first item above were eliminated, the annual savings would run into millions.

If you subscribe to the principle of PAT — and are concerned with the rising cost of health care — we urge that you:

1. **Use PAT whenever appropriate.**
2. **Urge your hospital to institute the program, if it already hasn't.**
3. **Recommend that your hospital staff Utilization Review Committee conduct an unannounced review of the patients on a floor or two of your hospital monthly.**

Great savings in total medical care costs can be accomplished in the most costly area — inpatient admissions — by the adoption and implementation of PAT, and monthly on-site utilization reviews.



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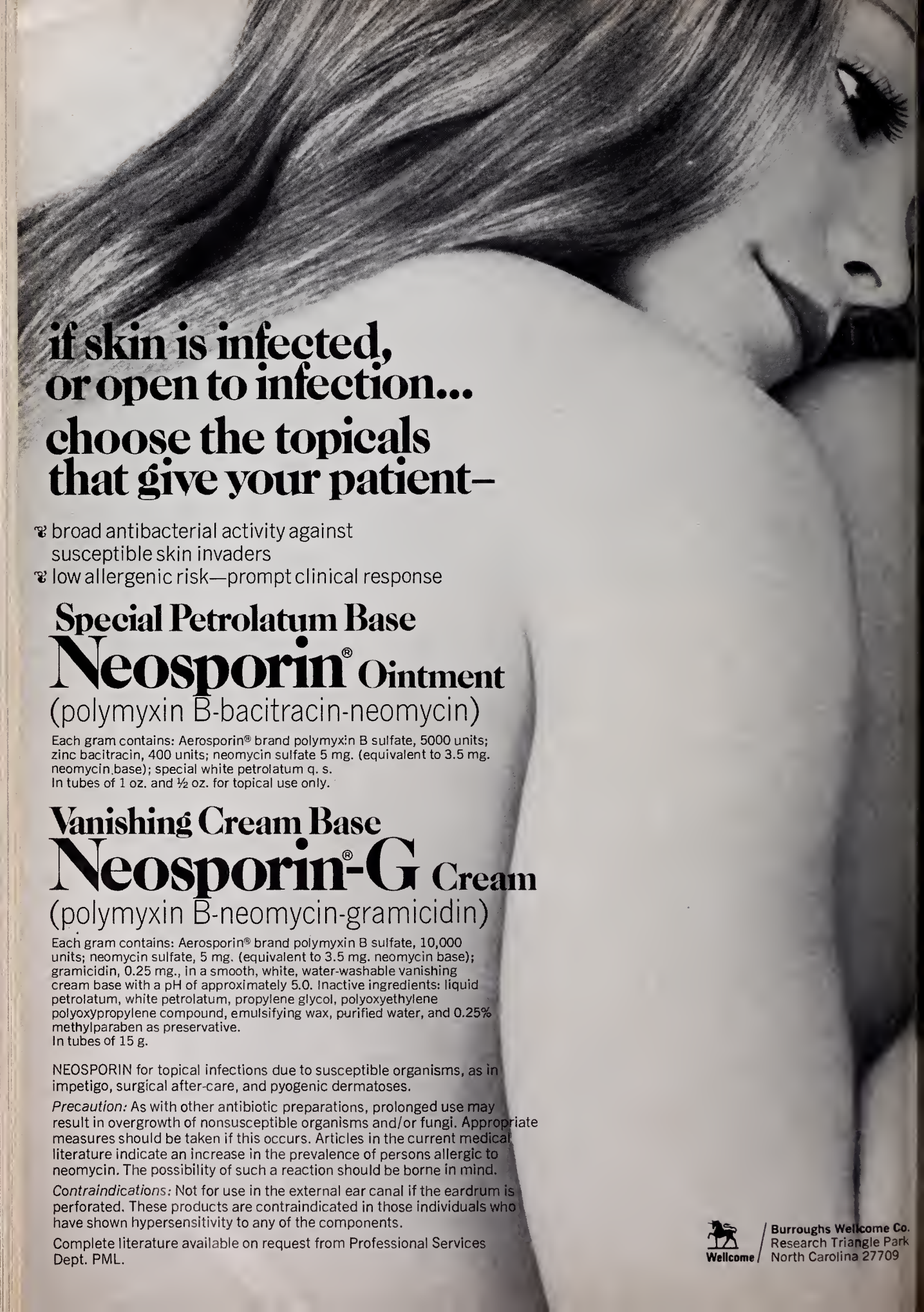
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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
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Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity ot the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk ot severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemie, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, eppeerence of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hemetologic investigation. Unexpleined bleeding involving CNS, edrenals, and G.I. tract hes occurred. The drug may potentiate action of insulin, sulfonylurea, end sulfonamide-type agents. Cerefully observe petients taking these agents. Nontoxic end toxic goiters end myxedema heve been reported (the drug reduces iodine uptake by the thyroid). Blurred vision cen be a significent toxic symptom worthy of a complete ophthalmological examination. Swelling of enkles or face in petients under sixty mey be prevented by reducing dosage. If edeme occurs in petients over sixty, discontinue drug.
Precautions: The following should be eccomplished et regular intervals: Ceretul detailed history for diseeso being treated and detection of earliest signs of adverse reections; complete physicel exeminetion including check of patient's weight; complete weekly (especially for the eging) or en every two week blood check; pertinent laboretory studies. Ceution patients about particlpating in ectivity requiring alertness end coordination, as driving a cer, etc. Cesos of leukemie have been reported In petients with e history of short- and long-term therapy. The majority of these patients were over forty. Remomber thet erthritic-typo pains cen be the presenting symptom of leukemie.
Adverse Reactions: This is a potent drug; its misuso can lead to serious results. Revlow detailed informetion before beglnning therapy. Ulceretivo esophegitis, acute and reectivated gastric and duodenal ulcer with perforetion end hemorrhege, ulceration end perforation of large bowel, occult G.I bleeding with anemia, gastritis, epigestric pein, hemetemesis, dyspepsia, nausea, vomiting end dierrhee, ebdominal distention, agranulocytosis, eplastic enemie, hemolytic enemia, enemia due to blood loss including occult G.I. bleeding, thrombocytopenie, pancytopenia, leukemie, leukopenia, bone merrow depression, sodium and chloride retention, water retention and edeme, plesme dilution, respiretory elkalosis, metebolic ecidosis, fatal and nonfetal hepatitis (cholestesis may or mey not be prominent), petechiae, purpure without thrombocytopenie, toxic pruritus, erytheme nodosum, erytheme multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing opidermolysis), exfolietive dermetitis, serum sickness, hypersensitivity angiitis (polyerteritis), enaphylactic shock, urticerie, erthralgie, fever, reshos (all allergic reactions require prompt and permanent withdrewal of the drug), proteinurie, hematuria, oliguríe, enuría, ronal teilure with azotomia, glomerulonephritis, ecute tubular necrosis, nephrotic syndrome, bilatorel renal corticel nocrosis, renel stones, ureteral obstruction with uric acid crystels duo to uricosuric action ot drug, impaired renel function, cerdiac docompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivescular granulomata, aggravation of temporal artoritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic emblyopia, retinal detachment, hearing loss, hyporglycomia, thyroid hyporplasia, toxic goiter association ot hyperthyroidism and hypothyroidism (ceusal reletionship not ostablished), agitation, confusional statos, lothargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations glddinoss, vertigo, coma, hyporventilation, insomnia, ulcerative stomatitis, salivary gland enlargemont
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—George Sarton, from "The History of Medicine Versus the History of Art"

Would it be useful in clinical practice to have government predetermine drugs of choice?

Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

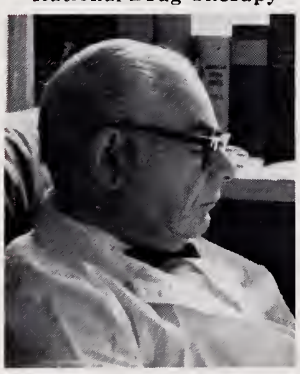
86.7%
No, it would not be useful.

Dialogue

Would it be useful in clinical practice to have government predetermine drugs of choice?

Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really determined.

The Bureau of Drugs h suggested the package i sert as a possible means communicating informati on relative efficacy of dru to the physician. I find th objectionable, since I not believe the physici should have to rely on th source for final scientif truth. There is also a pra tical objection: Since fe physicians actually di pense drugs, they seldo see the package insert. any event, I would mai tain that the physicia should know what drug l wants and why without d pending on the governme or the manufacturer to te him.

Undoubtedly, physician are swamped by excessiv numbers of drugs in som therapeutic categories. Ar I am well aware that man drugs within such cat gories could be eliminate without any loss, or pe haps even some profit, t the practice of medicin But, in my opinion, neithe the FDA nor any othe single group has the expe tise and the wisdom nece sary to determine the or "drug of choice" in a areas of medical practice.

Maker of Medicine

nneth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
Eli Lilly and Company



In my opinion, it is not e function of any governent or private regulatory ency to designate a "drug choice." This determinan should be made by the ysician after he has reived full information on e properties of a drug, d then it will be based on s experience with this ug and his knowledge of e individual patient who seeking treatment.

If an evaluation of comrative efficacy were to be ade, particularly by govnment, at the time a new ug is being approved for arketing, it would be a eat disservice to medine and thus to the patient he consumer. For exame, when a new therapeu agent is introduced, on e basis of limited knowge, it may be considered be more potent, more fective, or safer than oducts already on the arket. Conceivably, at is time the new drug uld be labeled "the drug choice." But as addinal clinical experience is cumulated, new evidence ay become available. ater, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B_{12} as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use – information that the pharmaceutical manufacturers must begin to provide if government regulation of "*drugs of choice*" is to be avoided.

Opinion & Dialogue

What is your opinion, doctor?
Send us your comments on the above issue.

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EDITORIALS

Introducing Doctor D'Elia



The "Jersey Shore" is one of the prides of our State. And, among the good things in the Monmouth County area, William John D'Elia must surely be counted. Dr. D'Elia was graduated in 1937 from Hahnemann and came to Monmouth County to serve his internship at the Fitkin Memorial Hospital. Subsequently he selected orthopaedic surgery as his life work, starting with a residency in that specialty at St. Luke's Hospital in New York. He rapidly advanced in that field in the central New Jersey area, eventually becoming chief of orthopaedics and fracture work at Fitkin and consultant at numerous other hospitals and agencies. Board certified in orthopaedics, he is a Fellow of the prestigious American Academy of Orthopaedic Surgeons. While these represent his contributions to the health of his patients, he has also contributed significantly to organized medicine in the Garden State. He has held many major offices, including the Presidency of the Monmouth County Medical Society, and has been Chairman of our State Society's important Committee on Medical Defense and Insurance. Dr. D'Elia is married to the former Agnes G. Gillespie of Spring Lake and they are proud of their three grown-up children: Janet, William, and Hugh.

We appear to be entering on a decade of decision in the field of distributing medical care. In these times the occasion calls for a helmsman worthy of the cruise. And in fulfilling that need, William John D'Elia will not disappoint us.

Our New Auxiliary President



She comes all the way from Iowa. She received her college degree from Morningside College in Sioux City. Also a student there was Charles Gandek who, after receiving his

baccalaureate degree from Morningside, went on to Omaha where he earned his M.D. degree at Creighton. But before he left for Omaha, he married Ruth Hayward and took her with him. During Dr. Gandek's attendance at Creighton, World War II was on and Ruth Gandek worked in the legal department of the Martin bomber plant. After a brief period of working in Virginia, the Gandeks came north and settled in Middlesex County, where Dr. Gandek is now in general practice in Edison.

Mrs. Gandek has been on the board of the Middlesex County Tuberculosis and Health League, sings in her church choir, and serves on several church committees. She has been prominent in the Auxiliary to the Middlesex County Medical Society, having served in nearly all offices in that Auxiliary. She was Mental Health Chairman of the State Auxiliary and then worked her way up through the various chairs, becoming President in 1972. Her hobbies include raising African violets, target shooting, and photography, not to mention her having successfully reared three daughters all of whom are now married.

Is The Doctor Failing The Alcoholic?

When they talk about it, alcoholics and ex-alcoholics often charge physicians with being disinterested in treating them. And too often this is true. Alcoholics are not easy people to treat; you have to involve a whole family. They often don't tell the truth. They are not always conscientious at keeping their promises, sometimes they don't pay their bills, at times they get very nasty. Too often they seem to be badly motivated.

By a play on words, the concept of "illness" is translated as "something which is not my fault, which happens to befall me, and of which the doctor should cure me"—a description which might apply to pneumonia, but not to alcoholism. Alcoholism is an illness in the sense that it represents a physiologic inadaptability to handling alcohol, much as the diabetic has a physiologic inadaptability in handling sugar. However, we do hold the diabetic responsible for continuing to eat sweets after he learns of his metabolic disorder; yet we are asked to absolve the alcoholic from a similar kind of indiscretion on the grounds that this is his sickness. And perhaps the major deterrent to trying to treat the alcoholic is the doctor's usually poor batting average.

Yet, there are things that the physician *can* do. There is a place for disulfiram (Antabus®), and it calls for real pharmacologic judgment in prescribing it. When the alcoholic is so tense that he needs another drink, there is a place for a tranquilizer, for the wisdom of changing the medication from time to time, and of avoiding making a pill-popper where the cure might be worse than the disease. There is a place for Alcoholics Anonymous, and the sophisticated doctor knows what that place is and how to use AA. There is a time to send the chronic alcoholic to a hospital, rest home, or sanitarium—a need for medical flexibility in selecting the appropriate placement. The family doctor must work with the family. If the patient is male, the doctor may have one of three attitudes toward the wife: sentimental, punitive, or psychological. The sentimental practitioner will pity the poor wife who has to put up with so much misery having an alcoholic husband. The punitive practitioner will suggest that she must have driven him to drink with her nagging, coldness, compulsiveness, or her rejection. The doctor who is interested in psychological subtleties will realize that most alcoholic males are immature and dependent and wonder what there was in the woman that made her select this kind of mate.

Sometimes it looks as if we were failing a patient—indeed a family—in trouble when the physician dismisses the alcoholic as too much to handle, too hard to treat. There are, after all, even worse diseases, more refractory ones, diseases with a higher relapse ratio. And that should not stop us from trying to help someone in trouble.

ORIGINAL ARTICLES

Good health must be won, not bought. Patients have a responsibility here too.

Let Us Speak With Unified Voice*

William J. D'Elia, M.D./Neptune City

I am keenly aware that today you confer upon me an honor and a set of weighty responsibilities such as I have never had before. As I enter upon my tasks as 180th President of our distinguished Society, I pledge to you my constant best, I ask God for His help, and I ask you for your active, constructive advice and cooperation.

For two hundred and six years now The Medical Society of New Jersey has pursued its vigorous and productive existence, dedicated, as Article II of our Constitution declares . . . "to advance the art and science of medicine, elevate professional standards, promote the betterment of public health, and enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey."

I submit that those are far-reaching and important purposes and that the men who first conceived and gave them expression had almost prophetically discerning vision. Across the years we have pursued and progressively attained many of these goals, but though much has been accomplished much remains, because of the expanding world of concerns to which, in pursuit of those goals, we must address ourselves.

I shall not impose upon your time today to scrutinize and evaluate our progress toward the full attainment of all those enumerated purposes, but I should like to enlarge briefly upon the obligations which are ours as physicians today as we proceed "to promote the betterment of public health, and enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people . . ."

We in America are inclined today to delude ourselves with the idea that if we spend enough money on people we shall make them all healthy and long-lived. Nothing is farther from the case. Health cannot be bought and professional services are useless unless, in all areas where it becomes necessary, the patient cooperates—even when such cooperation means self-arraignment, self-discipline, self-denial, and self-control. To hold otherwise is dishonest. To spend money on health care that will not produce such cooperative response is sheer waste.

Therefore, as part of our service to the public as physicians, we must bring home to all our patients—and to all those who are interested in delivering high quality medical care with economy and efficiency—the realization that the responsiveness of the patient and his full cooperation in overcoming whatever maladies beset him are indispensable if he is to attain and retain good health. Good health cannot be provided; it cannot be bought. Like love and human respect, it must be won. Once that fact is popularly recognized and accepted we can look for real progress in the betterment of public health.

It seems to me that we have another job to do in our efforts to enlighten and direct pub-

* Presented before the 1972 House of Delegates, MSNJ, second session, May 7, 1972, Atlantic City

lic opinion in regard to the problems of medicine and health. One problem that looms large is the difficulty of satisfying the public demand for health care services with the limited number of personnel qualified to provide those services. The solution does not lie exclusively in increasing professional and paraprofessonal personnel. It lies also in getting legislators and program planners not to promise more than any system could deliver or any prudent nation afford. It lies in restricting the available services to what people fundamentally need, and to those who manifest such need. The deliverers of health care services today, work to exhaustion though they may, often are simply not able to take care of all who lay claim to their services. People have been encouraged to believe that they have a basic right to be well and healthy, and that everybody else has a corresponding basic duty to enable them to be so. The consequence is that the deliverers of health care services are blamed for not being able to fulfill—and inexpensively—the extravagant promises that others have unthinkingly made.

It is our responsibility as physicians, I think, to educate people—promisers and promisees alike—to the desirability and fundamental necessity of promising help only to those who really need it and only to the extent that it can be dependably delivered. That concept addresses itself equally to the preservation of high quality, the maintenance of availability, and the containment of costs of health care services.

Surely by now we have learned that in protection both of the public interest and of the status and reputation of our profession, we physicians must actively participate at every level in the planning and programing of health care services. We are the experts in estimating and providing the health care needs of our people. We must for that reason make our judgments known and our voices heard. There are those who are eager to usurp our proper role and function and to relegate us to subordinate and inconsequential status. But we owe it to ourselves, our profession, and our people to resist their presumptuous aggressions and to continue to supply the directions and services consistent with genuine public welfare.

To this end, we of medicine should be the prime movers in formulating and promulgating sound and practical guidelines for community health programs. We should welcome the opportunity and the duty to meet and mingle with consumer groups, to make certain that they have enlightened understanding and full appreciation of what constitute sound and workable solutions to the manifold and complex problems of the delivery of satisfactory health care services.

We must study any and all proposals for new developments so that we can with dependable authoritativeness lead the way to the acceptance of constructive changes and adaptations and to the rejection of those that do not so qualify.

To exercise this type of leadership we must fortify ourselves in every way, as individuals and as members of organized medicine. As individuals we must exemplify the integrity of character, the balance of judgment, and the concerned solicitude that have always distinguished worthy physicians and won for them respect and confidence. We must keep abreast of medical progress by consistent participation in continuing medical education. The Medical Society of New Jersey should proceed without delay to formulate, survey, and accredit programs.

As members of organized medicine, we must unselfishly give of our best to strengthen and unify our cooperative endeavors for the public good. Through the peer review process we must work together to safeguard utilization of facilities and services, to exercise effective quality controls, and to contain costs. We must with firmness and fairness impose salutary discipline upon any within our ranks who transgress the canons of medical ethics or the standards of professional conduct.

We must strengthen our relationships with

the State Board of Medical Examiners and work with them toward the practical and effective enforcement of the laws which bear upon the preservation of high standards of medical practice in New Jersey.

We must look to mechanisms within our Society and re-evaluate the inner workings and decision-making processes so as to speed up the development of decisions to accomplish more rapid and responsive activity.

The committee system presently in effect affords the opportunity for a substantial number of our members to have a voice in the affairs of the Society. At the same time, it carries along with it the inherent inability rapidly to resolve important issues and quickly to implement a decision once made. The House of Delegates historically has attempted to deal with the items before it by specifically indicating each course of action to be pursued. This means that if subsequent to the annual meeting the factual situation surrounding an action is altered, the Society is incapable of shifting its position because a hard and fast line of demarcation was set. . . . These are all matters that I think we should review, re-evaluate, and act upon.

All this means that we must have unity—of purpose and of action. This is no time for dissension or division. If we have differing opinions, let us, in a spirit of enlightened dispassionateness, resolve them in our councils and committees, and by democratic methods let us arrive at reasonable decisions that will prevail. Only in this way can we hope to render the constructive service of which we are capable. Only in this way can we acquit ourselves of our individual responsibilities, advance our profession, and properly serve the best interests of our people and of our country.

Doctor Merlin K. DuVal, Assistant Secretary of the Department of Health, Education, and Welfare, recently offered some advice that is relevant to these observations of mine. Addressing himself to his fellow physicians, he said:

> "If we are to be respected, we are going to have to learn to speak with a more unified voice. If you expect to be heeded, you must speak in a manner that convinces the program-maker, the law-maker, and the public that you are speaking in the public interest and not mainly to protect the established ways that are best for your particular interest. If you speak with a multiplicity of voices and concerns, little will be heard. At best the results will be confusing; at worst, they will be inefficient."

As one means of developing that unified voice, our Council on Public Relations, with the help of its newly engaged public relations counsel, is considering the desirability of encouraging component societies to sponsor regular local radio broadcast programs, on the basis of patterns offered to them by The Medical Society of New Jersey. I think this would be a valuable contribution to improve positive public relations.

We are faced by many challenges. Let us close ranks, get to work, and do our job, together.

2100 Corlies Avenue

Blood Banks Disaster Plan Manual

A Disaster Plan Manual, which provides a system of coordinating individual efforts of the American Association of Blood Banks (AABB) into one effective, professional unit during disasters, has been developed by the AABB's Committee on Disaster Planning. The manual urges close cooperation and coordination between AABB participants and local civil defense authorities. Copies may be obtained from the American Association of Blood Banks, 30 North Michigan Avenue, Suite 133, Chicago, Illinois 60602.

The success story of the antibiotics may be making us careless in identifying subphrenic and perinephric abscesses

Perinephric Abscess With Subphrenic Extension

A Case Report

Julian I. Joseph, M.D. and Jayantilal Patel, M.D./Wayne*

Presented here is a case which illustrates the difficulty in diagnosing both perinephric abscess and subphrenic abscess. But the consideration of these diagnostic possibilities permits steps leading to a diagnosis. For either condition, an incision and drainage procedure is mandatory. The present case is that of a perinephric abscess with massive subphrenic extension.

A 63-year old female with a seven week history of anorexia following a low-grade febrile episode had a one week course of antibiotics. She developed edema of the legs and abdomen, and had a history of moderate alcoholic intake. Temperature on admission was only 98.6. Abdomen was distended and a fluid wave palpable. Legs had four-plus edema. Urine culture showed Proteus mirabilis 300,000 organisms per milliliter. Chest x-ray suggested a "possible right parahilar infiltrate." Abdominal film showed ascites, a right renal staghorn calculus, and elevation of the right hemidiaphragm with suggested loculated fluid medially. The hospital course was afebrile but she became confused. Neggram was started and subsequently we gave Polycilline®. She developed leucocytosis (19,600), azotemia (BUN 50), and elevated plasma ammonia. She died on the eighth day after admission.

* Dr. Joseph is associate pathologist at the Bergen Pines County Hospital in Paramus and Dr. Patel is Resident in Internal Medicine, at the same hospital.

Autopsy revealed a contracted right kidney (Figure 1), which had a dilated pelvis filled with a large staghorn calculus obstructing the calyces. The right ureter was dilated, and it contained 6 milliliters of purulent fluid. Just above the superior pole of the right kidney appeared an abscess cavity containing purulent content. A thin septum separated this from a much larger cavity (Figure 2) which extended from the retroperitoneal space to the inferior aspect of the right diaphragm, and formed a large subphrenic abscess. It contained about two pints of greenish, moderately thick pus. A fibrous wall enclosed the abscess anteriorly, inferiorly, and laterally. Its superior surface was the right diaphragm, the medial border merged with the falciform ligament of the liver, and the inferior surface principally was the superior surface of the right lobe of the liver. The liver was cirrhotic and somewhat shrunken. Almost 4000 milliliters of serous ascitic fluid were found in the peritoneal cavity, which was totally separate from the subphrenic abscess. Evidently the perinephric abscess had pushed peritoneum anteriorly and inferiorly, probably by evagination of the peritoneum between the bare area of the right lobe of the liver and adjacent inferior right diaphragm, thus forming an enclosure. There were right pleurodiaphragmatic adhesions, right lower lobe atelectasis and small emboli in right and left lungs but without infarction. Bilateral serous pleural effusion was present. The left kidney was pale and edematous but otherwise not grossly remarkable. The large subphrenic abscess grew multiple organisms, including

Klebsiella, Proteus mirabilis, Streptococcus fecalis, Streptococcus zymogenes, Pseudomonas, E. coli, and Enterobacteria. Gallbladder, stomach, and appendix had no intrinsic disease.



Figure I—Gross photograph of the right kidney. The kidney is scarred about a large central calculus. The arrow points to the perinephric cavity which had contained pus in situ. A dilated right ureter is noted near the left lower corner of the photograph.

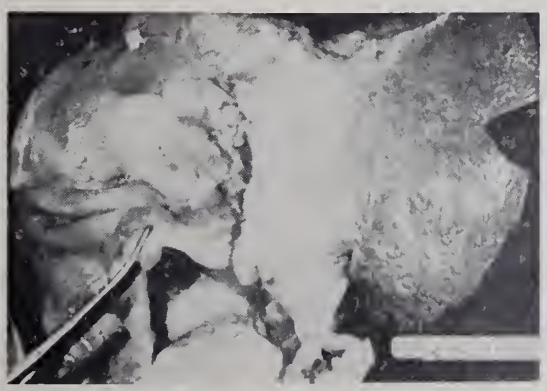


Figure II—The dark space below the clamp is the main subphrenic cavity. The clamp holds the diaphragm. Fibrinopurulent exudate can be noted on the floor of the abscess cavity, which is the superior border of the right lobe of the liver. The lower right corner shows a fibrous wall considered to be thickened peritoneum, which is continuous with the diaphragm. Note the medial demarcation by the falciform ligament. The liver is cirrhotic.

Perinephric abscess[1, 2, 3] is an uncommon disorder which today is generally a complication of local pyelonephritic renal disease. The use of antibiotics is considered to account for the marked reduction of hematogenously seeded perinephric abscess found years ago. The symptoms are vague but fever, pain, and a mass are generally found. The diagnosis is difficult but can often be made. Salvatierra and his coworkers[1] found that, in their series, a correct clinical diagnosis had been made in 39 per cent and in an additional 27 per cent at operation. A subacute or chronic febrile episode with demonstrable renal disease, (especially with the presence of a flank mass) should make one consider the diagnosis. An abnormality of the renal shadow and fixation of the kidney have been considered the best radiologic signs. Elevation of the diaphragm, pleural effusion, or a basal pneumonic shadow are helpful associated signs. Therapy is incision and drainage, along with antibiotics, sometimes with nephrectomy. Mortality is high even with surgery: in the 30 per cent range. Surgical intervention, however, is considered mandatory.

Subphrenic abscess has shown alteration in the antibiotic era, progressing from a fulminant disease to an indolent process. The fever is low-grade and the signs and symptoms nonspecific, i.e. malaise, lack of well-being, anemia.[4, 5] The causes today are postoperative states following gastrectomy, cholecystectomy, splenectomy, and after pancreatic and esophageal surgery.[6, 7] The abscess may appear years after the original operative procedure. Perforated ulcer and ruptured gangrenous appendix are now relatively uncommon causes of subphrenic abscess. Therapy with antibiotics and operative drainage yields a mortality of about a third.[8, 6] Chance of a fatal outcome is doubled without surgical intervention.

Radiologic techniques can establish the diagnosis—elevation of the diaphragm, loss of movement, and thickening of the diaphragm.[9, 7]

Associated pleural effusion and pneumonic changes are suggestive. Four views of the diaphragm should be taken: PA, lateral, PA-penetrated view, and lateral-penetrated view.

This case illustrates principles common to both perinephric and subphrenic abscess, i.e. low grade symptomatology, importance of considering the diagnosis, value of radiologic findings, and the need for surgical therapy.

The ordinary subphrenic abscess is an intraperitoneal process which because of its location may present a problem in method of drainage.[10] A subcostal incision[6] *via* the shortest route to the abscess cavity (remaining as much as possible outside the peritoneal serous cavity) is suggested. Because of the large subphrenic abscess in this case, its enclosure, its accessibility posteriorly, anteriorly, and laterally, one would expect surgical intervention here to present somewhat lesser technical difficulty.

Cirrhosis underlay the infection. But our case also illustrates how the use of antibiotics can be a two-edged sword, masking the diagnosis and changing an acute process into an indolent one. The subsequent escape of microorganisms from the initial influence of the antibiotics in subphrenic abscess[4] is considered to be the cause for clinical reactivation, which may be very severe.

The authors wish to acknowledge the technical assistance of Richard Mendes, photographer at Bergen Pines County Hospital

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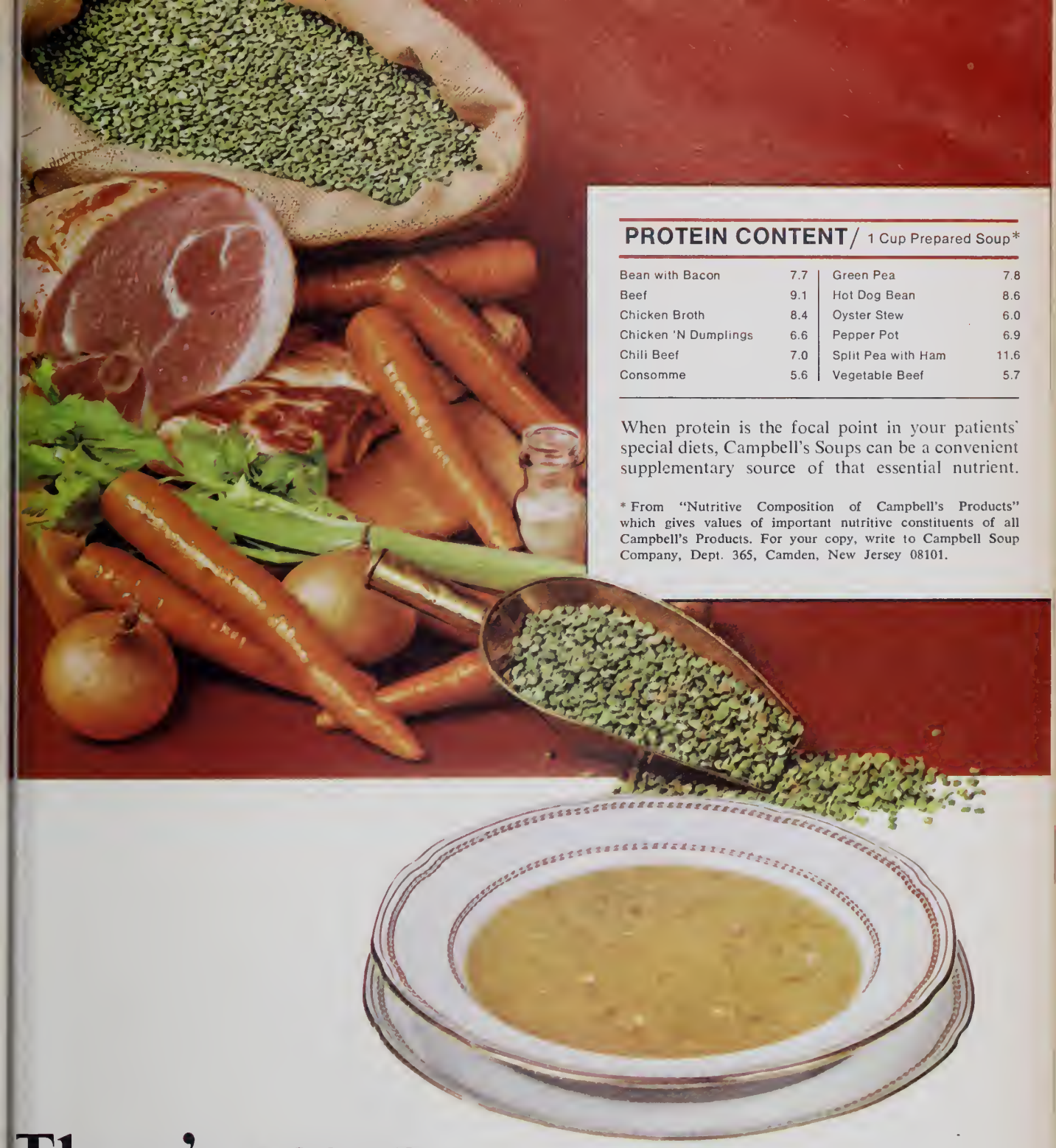
25 Tammy Terrace

New Drug Testing Facility

Biochemical Procedures, a clinical laboratory in North Hollywood, California, has been awarded a contract by the U.S. Army to conduct a drug identification program for servicemen in the Sixth Army and the Pacific Command. Biochemical Procedures is an affiliate of Mead Johnson and Company.

The identification program will be directed to that part of the Pacific Command area consisting of Japan, Korea, Hawaiian Islands, and Okinawa. In addition, seven Sixth Army facilities in the U.S. will be included in the program. This program is part of an Army project to identify users of drugs. Urine samples will be delivered to the laboratory for analyses using sophisticated technics under the direction of biochemists. Drugs which will be identified in the program are: morphine, barbiturates, amphetamines, and methadone. When the analyses of the samples are completed, the results will be communicated immediately to the appropriate military authorities.

Because of the growing seriousness of drug addiction, Biochemical Procedures has dedicated a major portion of its new California laboratory to be used exclusively for drug screening. The laboratory has the capability to conduct 10,000 drug screening tests per day.



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the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vaginal cytology slide—balanced "pink and blue.")

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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The *Special Note*, *Contraindications*, *Warnings*, *Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

Early surgical resection is not always the proper choice in handling brain tumors.

Management of Brain Tumors

Ira S. Ross, M.D./South Orange*

Recent adjuncts to medical treatment of brain tumors—the steroids and megavolt radiation therapy—call for re-evaluation of the timing of medical and surgical intervention. Correlated data from electroencephalography, brain scan, echoencephalography, special cytology, and x-ray, including angiography and pneumoencephalography have added to (but not substituted for) clinical acumen, based upon the natural history and knowledge of neuropathology and neurophysiology, including neuropsychology and physical diagnosis. Above all, however, an awareness of psychiatric aspects concerned is essential to the proper management of the patient and relatives because meaningful decisions must be made in time to save vital function where the quality of life to be saved depends so much upon making a proper decision at the proper time. These technical decisions often rest upon acquiescence and the granting of permissions by emotionally disturbed relatives.

The Psychic Threat Implied and the Reaction Thereto

No matter how great the belief in the dichotomy of body and soul, where disease concerns the brain the reaction is holistic. Change in behavior is anticipated and fear enters the attitude of concern for the patient. Profoundly irrational feelings are stirred by the threat implicit in damage to the brain. The cardiac patient and his family have little reluctance to total resignation to the mechanistic routine of the cardiac intensive care unit which includes a battery of impersonal, routine, printed orders and paraphernalia that preclude human choice of decisions even concerning state of consciousness or mobility. However, great anxiety and demand for doing something coupled with subtle unconscious resistances to getting things done comes rapidly into the scene where the disease threatens the brain, not so much perhaps by stroke as by tumor. This in spite of the fact that most brain tumors pose no immediate threat to life and very many may best be left undisturbed and undisturbing. However, very often where speed of decision does become vital, psychiatric factors may prove insurmountable to proper handling.

Surgical Intervention Versus Medical Management

Exploratory intervention with attempt at surgical cure has been the rule in the first half of the twentieth century. As steroid administration has reduced the need for mechanical decompression in the presence of cerebral edema, radiation therapy presses hard to make surgical intervention a last rather than a first resort and timing becomes of the essence in the use of current therapeutic modalities.

Headache, nausea, vomiting, and papilledema are late and terminal manifestations of brain tumors. The early recognition of brain tumors concerns knowledge of the age incidence of the various lesions and the awareness of common accompanying signs and symptoms, the details of which are beyond the scope of this paper. The range of signs and symptoms of brain tumors goes from the asymptomatic—with no signs—that are discovered among incidental findings at autopsy (as may be the case in undiscovered meningiomas), to neurologic deficits that must be lived with as is the case of a young woman in my practice whose

*Attending Neurologist, Saint Barnabas Medical Center, Livingston, New Jersey.

vision has been impaired all her life by a supra-sellar cyst that she and her physicians and surgeons believe is better left alone. Epileptic symptoms and signs commonly associated with brain tumors are many times better treated with anti-convulsant medication than with attempted surgical eradication. This is true with a fourteen-year old boy in my practice with an established diagnosis of parietal racemose aneurysm. There are probably many small astrocytomas being treated by anticonvulsants with better quality of life than would be the case were their life experience to include a craniotomy and an epileptogenic post-operative scar.

Where Time for Decision and Management Counts

There are situations in the diagnosis and treatment of brain tumors where timing of intervention is of prime importance. Here the art of the physician is taxed to the utmost in situational handling. Some brain tumors make themselves compellingly and rapidly apparent before the patient or family can cope with the unconsciously determined defenses that abound in the face of the obvious diagnosis. The onset of a glioblastoma multiforme or malignant change in a previously silent astrocytoma provides cases in point. The diagnosis can oftentimes be made on the telephone sometimes before the EEG, echo, brain scan, or arteriogram add positive evidence to the picture. In such instances speed is essential because these malignancies spread with the speed of inflammatory processes. The first major problem of management concerns the psychiatric aspects of the reaction to the diagnosis. The most common might be called the "distant doctor syndrome." It is probably a mechanism of phobic displacement with flight. Invariably the patient with imminently life-threatening brain tumor has a relative who is a neurosurgeon who does not want to be involved but needs to have a friend in a remote city see the patient. Days, weeks, and lives are lost at this stage of the game. Furthermore, in this situation where the script cannot be printed out like the orders in an intensive cardiac care unit much "expertise" crops up out of the hinterlands and it can be very threatening. All this adds to the need for "formidable optimism" required, as Foster Kennedy put it, in a game where the dice of the gods are loaded. Hostility abounds where the threat to life is veiled by the inscrutable exterior of the human skull. Not the least common reaction on the part of a mother is the apparently unconsciously determined delusion that the man making the diagnosis has put a curse on the patient. If he had not discovered the condition it would not have existed. A situation in point concerned a four-year old boy whose mother had lost another child. She was reluctant to give permission to necessary surgical intervention and a neurosurgical colleague requested help. The child had an obvious iter block. The mother was gently informed that the little boy had all the signs of a brain tumor and that without surgery he would surely die. A lateral ventricle-to-atrium shunt saved his life but his father instituted suit for negligence because of the emotional reaction of the mother to the presentation of the facts which allowed her to decide to give permission for operation. Sometimes hostility is pitched with a mean curve.

Case Material

Two cases illustrate the importance of timing treatment insofar as treatment timing delay may affect the quality of life that may be saved. The first concerns a forty-five year old engineer who complained of mild headache for three weeks and had numbness of his right hand and forearm. History disclosed that he had gross amnesia for two or three business conferences within the last month. Physical examination showed very mild right pyramidal signs, no papilledema, right sided hemihypalgesia most pronounced in his forearm and the ulner aspect of his hand with no speech deficit, and no cortical sensory loss but a suspicious right visual field cut. His sensorium was quite clear with the exception of his own awareness that he did not remember the content of recent office conferences. Specific testing for retention, recall, calculation, and recent memory was otherwise sound. The pa-

tient was aware of the seriousness of the diagnosis and remained throughout calm, cooperative, and compliant. His wife professed utmost confidence which turned out to be something of a manifest conscious or unconscious denial. On hospital admission, EEG and echo were normal, as were brain scan and initial arteriography reading since there was no vascular displacement. However, a delayed emptying vein according to criteria of Leeds and Taveras[2] gave indication of possible malignancy. Spinal fluid pressure, appearance, and routine cytology and chemistry were entirely normal. However, by special technic of microfiltered cytologic smear (performed in Dr. Wertlake's[5] laboratory for special cytology at Saint Barnabas Medical Center Livingston on two occasions) cells characteristic of glioblastoma multiforme with numerous mitotic figures were demonstrated. Steroid medication was started and megavoltage cobalt radiation was directed primarily to the area of the left postero-latero-ventral nucleus of the thalamus with secondary total brain irradiation. Within four days there was improvement of headache, pyramidal signs, and hemihypalgesia. There then ensued a delayed explosion of the "distant doctor syndrome." The patient's wife had been previously employed by a general pathologist. He was not certain he could tell anything about the cells in the special cytology smears but he had a friend who was a neurosurgeon and neuropathologist who, he was certain, could. The pathologist was quoted as being firmly of the conviction that the patient should be surgically explored. This led to a family medical conference, interruption of radiotherapy, and professorial consultation with kith and kin present. The professor agreed with the diagnosis but felt that steroid treatment for palliation and a short span high quality of life period was preferable to radiation therapy, the steroid to be combined with chemotherapy and radiation therapy only to be used as a last resort. He felt that the tumor site was not neurosurgically accessible. A consultant oncologist did not agree that chemotherapy was in order and opted for resuming radiotherapy. Somehow, positive transference, the philosophy of *da sein* (the patient was never transferred out of the hospital and the radiation therapist stood by and only a week was lost) reason, or providence, prevailed and the family constellation settled on the decision to restart and carry through with 6500 rads of cobalt radiation.

The patient was forewarned of anticipated depressive reaction to his experience. His wife was instructed in the psychiatric convalescent attitude and the need for prolonged diminished demand upon and expectation of performance by the patient. Neurologic signs cleared rapidly at first and then slowly. The patient lost all his hair and slowly regrew it. He became moon faced and obese with altered habitus, sloppy stance, and slow gait. Headache persisted but grew milder. The patient's spinal fluid showed ghost cells of bizarre form for two months and finally became cell-free even in the filtrate.

There was a recrudescence of the distant doctor syndrome a month after radiation therapy was completed when, without having seen the two slides showing malignant cells (but by whom the family had the arteriograms reviewed), a neurosurgeon in a remote city volunteered in writing that the diagnosis could only have been presumptive without exploration. A fearful hazard to practice is the doctor who makes more money testifying in court than in providing medical care.

As steroids were withdrawn the patient complained of arthralgic knee and bursal, subcalcaneal pains. Tricyclic anti-depressants were used for the patient's somewhat apathetic depression. For months he did not read, show initiative, or converse very much. Aspirin was used for his aches and pains. A month after three months of steroids were stopped a doctor relative who saw the patient at a Bar Mitzvah party said, "He is himself again." He returned to full-time work ten months after the diagnosis of glioblastoma multiforme was made and seven months beyond his life expectancy.

A second case concerns a forty-seven year old editor, father of a twenty-year old son. He first experienced sudden and transient inability to

comprehend what he was reading at work on a Monday morning. He recovered the ability to read in a few minutes but felt faint and nauseated for a time. When seen in neurological consultation three days later he had a mild headache, pupils and optic discs were physiological. He had no speech impediment but he had a right crescentic visual field cut and hypalgesia of his right upper and lower extremity with no other pyramidal signs than diminished right arm swing. Arteriography demonstrated a tumor blush in the left occipital pole. A branch of the left occipital artery leading to the stain appeared to bend as though around a small mass. His wife and the patient were appraised of the seriousness of the situation. It was important for her to know the possibility of encroachment on the visual receptive speech area and the possibility of the patient becoming alexic even during treatment, as tissue swelling at the very least had to be anticipated and it was thought important to prepare him and her for the temporary loss of the means of his livelihood and the core of his identity. In this case the first "distant doctor" was a relative who endorsed radiation treatment but requested consultation by a local neurosurgeon. He, in turn, felt that immediate neurosurgical intervention was in order believing that the tumor might be removable without rendering the patient alexic. He thought a relatively benign tumor was undergoing malignant change. Another "distant doctor" relative appeared from a remote town who felt the patient should be studied by still another neurosurgeon in a nearby city. The patient was transferred to a university hospital where he spent two weeks. Bilateral arteriography was carried out to investigate the possibility of multiple tumors. His partial hemianopia became complete and he became unable to read. During this time, intensive steroid medication was started. The last neurosurgeon agreed that the tumor was malignantly invasive and that radiotherapy was the treatment of choice. This was carried out as in the first case. Within three weeks, on continued intensive steroid and radiation with 6500 rads, the patient became able to read fairly well and all but a peripheral crescent of his vision returned to the right field. His affect was pleasantly apathetic. His appetite became enormous, his face round and full, and his body rotund. Steroid dosage was diminished from .75 milligrams of Decardon® four times daily to .75 milligrams daily, gradually, in one week. At this dosage he experienced headache. The original dose was restored but by the following week the patient again had right hemonymous hemianopia, alexia as well as papilledema, and increased knee and ankle jerks. It was felt that recrudescent cerebral edema had broken through steroid control and that surgical intervention would be necessary for those elements of tumor not destroyed by cobalt radiation.

The second case like this chapter in medical progress is incomplete. With the brain we deal with a sealed box. Diagnoses are made most often by deductive inference. The most malignant brain tumors are the most radiosensitive. The least radiosensitive tumors are sometimes relatively innocuous and compatible with good quality of life. This is not to say that brain tumors are at any time desirable attributes. No matter what the individual's philosophy, religion, or degree of intellectual sophistication, the brain is the most emotionally charged organ in the body and the approach to treating it demands expertise of patient and family handling, requiring heavy reliance upon psychiatric knowledge. Early diagnosis of brain tumors necessitates knowledge of their symptoms and their age-related incidence. Treatment requires judgment values concerning the use of steroids, radiation, and/or chemotherapy and the optimum timing of neurosurgical intervention. The occupation of the patient and the site of the tumor pose problems regarding the quality of life even after successful intervention. There are optimum times for decision for which no timetables exist. The tendency to dissipate decision-making to numerous and often remote physicians may be a form of unconsciously motivated resistance endeavoring to stop the clock in a wish to undo reality. Like other neurotic behavior, it is self-defeating. Every time the skull has to be opened surgically, the problems of Pandora threaten to escape. Early

diagnosis and radiation therapy offer treatment with the box closed, especially where the diagnosis is glioblastoma multiforme.

Summary

1. Some malignant brain tumors are amenable to radiation therapy alone.

2. Steroid treatment by ameliorating cerebral edema can offset the need for surgical decompression.

3. In the case of malignant change in astrocytomas, it may be preferable to kill malignant cells first, hold down edema with steroids, and resect the slower growing, radio resistant tumor, if necessary, at a later date.

4. Great skill and understanding is needed to offset what appears to be unconsciously determined resistances to accepting decisions for intervention in cases of brain tumors, by the ruse of involving too many doctors, particularly relatives.

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179 Irvington Avenue

Dealing with Personal Crises

"Why can some people bear up well in the face of personal adversity while others flounder, panic, or fall apart? How can we cope constructively with a difficult situation when the props seem knocked out from under us?"

These are some of the questions discussed by Theodore Irwin in *How to Cope with Crisis.* This new Public Affairs Pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

Mr. Irwin defines a personal crisis as "a critical transition point or a disruption of the person's 'steady state' of existence by a disturbing situation . . . the victim is thrown off balance. For him, the crisis represents a turning point for better or worse, depending on the decisions he makes." A "normal" crisis does not continue indefinitely; generally, Mr. Irwin writes, "the strong reaction lasts from one to six weeks." And a crisis, he feels, can shake up old habits and can help us chart new ways. The most common reaction to the impact of trouble is bewilderment. The victim may feel helpless and confused, and may "search for an answer that will deny the reality of what has happened." Eventually he must decide whether "to stay and fight—attacking the problem head on, trying to manipulate it, and taking action"—or to attempt to flee from reality. Others, Irwin points out, become bitterly resentful at misfortune, while some passively wait to be rescued.

To show the many different ways of dealing with crises, Irwin offers case illustrations that cover a number of upsetting experiences. Among them are situations involving serious illness or accident; the family breadwinner's loss of his job; premature birth; divorce or separation; death of someone you love; news of a fatal illness; and psychological emergencies of children.

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Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

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Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of Insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

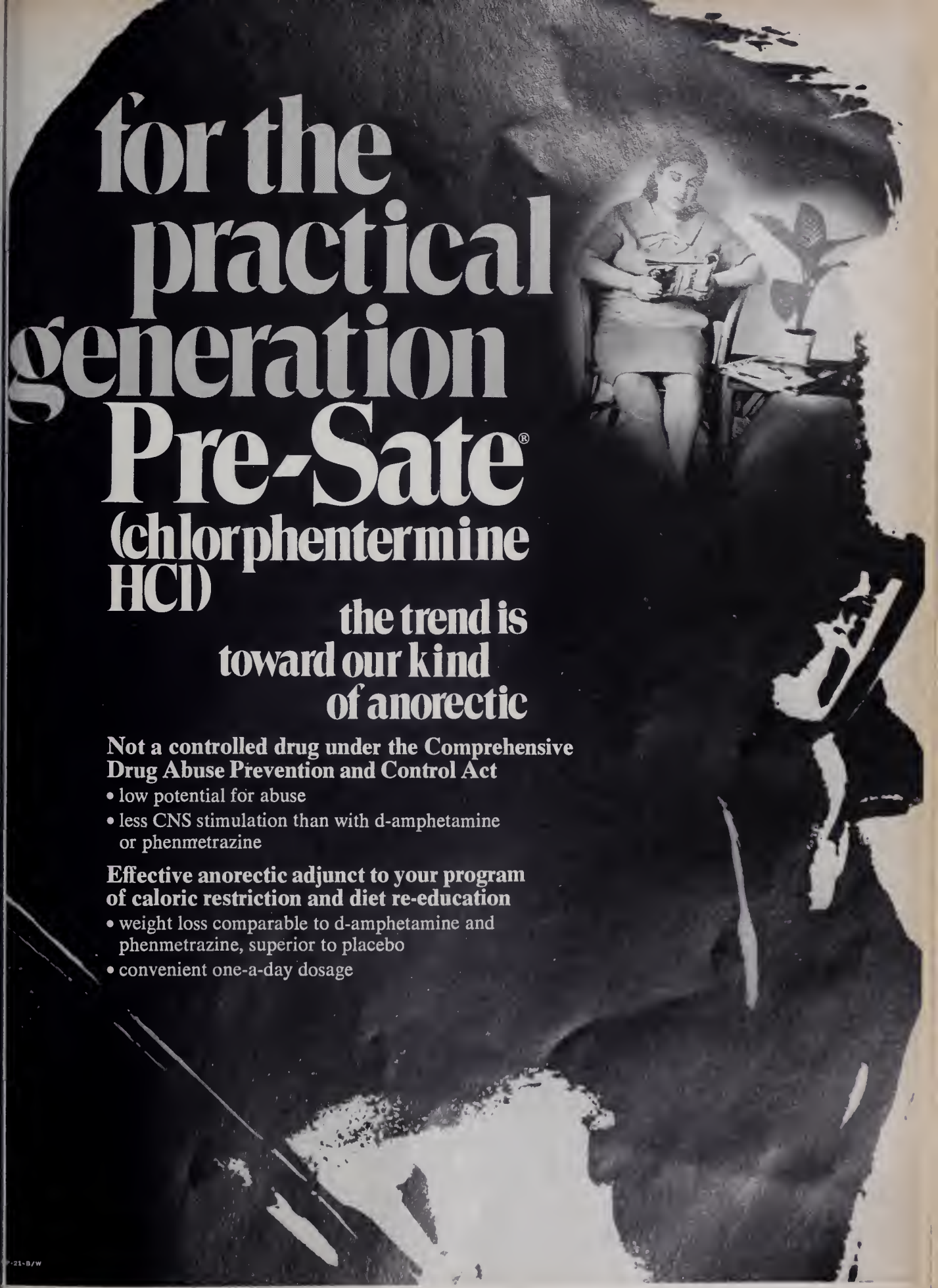
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

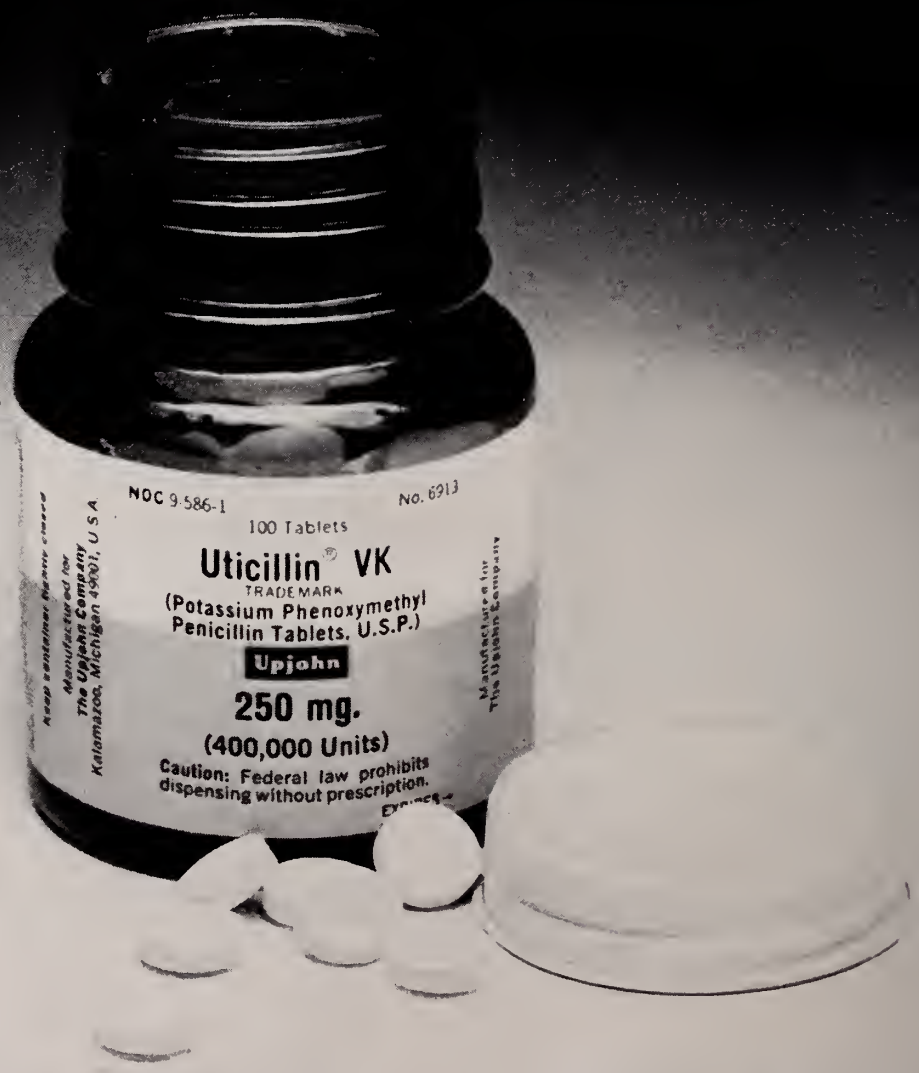
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Foot imbalance is here offered as a cause for the chondromalacia that afflicts so many runners.

Chondromalacia in Runners

George A. Sheehan, M.D./Red Bank

Chondromalacia of the patella is one of the most frequent of the non-traumatic athletic injuries. Almost 20 per cent of distance runners polled by a national magazine, *Runners World,* suffered knee symptoms sufficient to interrupt and even end their running careers. America's new middle-aged athletes (according to reports of the American Academy of Orthopedic Surgeons) are limping to physicians in record numbers with knee problems. Most of these difficulties are due to chondromalacia. Etiology of this disease remains a mystery. Recent reviews point out a lack of consensus on what initiates and continues the damage to the patella.

Review of the literature reveals a variety of recommended therapies. Rest leads the way, followed by Butazolidin®, steroid injections, immobilization, quadricep exercises, transplantation of the tibial epiphysis, and operation with shaving of the patella. None seems to afford more than temporary relief.

My personal experience as a runner has convinced me that chondromalacia, in many instances, if not most, stems from an imbalance in the foot. Thus, in my daily run, traveling against traffic was a painless outing, but should I run with traffic, I would soon develop pain in my left knee which would worsen with each session. The apparent source of the difficulty was that the crown of the road caused me to run on the inside of my left foot traveling with traffic, but on the outside while going against it.

Shortly thereafter I began a correspondence with a first-class runner who had been suffering with symptoms of chondromalacia for more than two years. Running despite severe pain, he was able to confirm the fact that running on the outside of the foot relieved his symptoms. Unfortunately, we did not take the next logical step until he developed arch symptoms. After these developed, he had inserts made and soon was running long distances without trouble. Within a short period of time he ran the fastest marathon of his career.

His case and two others are briefly summarized.

Case One: A 26-year old ex-Marine with a two-year history of typical chondromalacia treated with rest, Butazolidin®, and steroid injections became free of pain after supports were made by his podiatrist from molding and cast of foot.

Case Two: The patient developed signs and symptoms of chondromalacia, made worse while running, and when seen by a podiatrist was found to have a short first metatarsal with excessive pronation. After insertions of corrective support he became asymptomatic, and in ten days returned to number one position on his team.

Case Three: A 28-year old runner, with a three-month history of knee pain due to chondromalacia, unimproved by rest, had (on his own) bought and tried arch supports and reported that "in one week I was able to run with no pain whatsoever."

Chondromalacia is an overuse syndrome of unknown etiology. Evidence is here presented that the additional factor to overuse (5000 foot strikes a training day—90 a minute for one hour) is a peculiarly susceptible indi-

vidual. This susceptibility arises from an unstable foot with the mechanical imbalance transmitting a torque to the knee and causing the patella to override on the lateral condyle. What confirms the foot as the source of the problem is that knee pain is relieved when the crown of the road throws the runner on the outside of the foot (reversal of direction on the track will do the same thing) and that corrective inserts give permanent help.

Overuse alone is not the cause. Although the physician may be surprised or even appalled at the distances covered daily by these runners, he should be aware that many athletes are completely asymptomatic running 70 to 100 miles a week.

We need a fresh look at all overuse syndromes of the leg, knee, hip, and back to see if abnormalities of the foot are present. Repeated stress fractures (I know of one runner who had a stress fracture every year in college) point to a basic mechanical problem involving the foot-leg relationship.

This basic abnormality of the foot must be diagnosed before we can give overuse victims anything more than palliative treatment. Our best help in these injuries is a thorough investigation of the foot and the foot strike. Podiatrists, who have outstripped orthopedic surgeons in diagnosis and even more in treatment, especially in the molding and casting of corrective inserts, should be consulted for their valuable aid.

79 West Front Street.

Target: Alcoholism

The government has elevated alcoholism as a priority target with the 1972 submission to congress of the first special report on alcohol and health. The report contains current information on the health consequences of using alcoholic beverages. No recommendations for legislative action are being submitted at present.

A $200,000 campaign has been started by the HEW Department to call the public's attention to warning signs of alcoholism and to discourage drinking to excess. Although the first efforts will be made in the public education field, the government's prime emphasis remains on rehabilitation and treatment.

The 120-page report summarized current scientific knowledge on the health consequence of using alcoholic beverages, and represents the first part of a three-year comprehensive study being undertaken by the National Institute of Alcohol Abuse and Alcoholism to help the nation combat alcohol-related problems.

In the initial fact-finding phase, NIAAA established a consultant task force to gather and develop information, analyze existing literature and to identify those human health problems that are correlated with the use and abuse of alcohol.

Subsequent phases will design and test methodologies for assessing precisely and completely the ways alcohol affects selected areas of well-being, as well as identifying the most feasible methods for mounting effective prevention and treatment programs in the field of alcohol abuse and alcoholism.

The report said that alcohol is the most abused drug in the United States, estimating that there are now 9 million alcoholics or problem drinkers in America—almost 10 per cent of the work force.

From the February 29, 1972 release of the Washington, D.C. office of the AMA.

140/90 is normal blood pressure... or is it?

An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

Study Findings. Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"[1]—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

Other Studies. Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

Another Point of View. Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."



Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

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25- and 50-mg tablets

HydroDIURIL®
(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Kannel, William B., *et al.*: "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Consultant, Jan. 1971.

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Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

PRECAUTIONS: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Hypochloremic alkalosis occurs infrequently and is rarely severe. In severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur if dietary salt is unduly restricted, especially during hot weather.

Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics.

Pathological changes in the parathyroid glands with hypercalcemia and hypophosphatemia have been seen in a few patients on prolonged thiazide therapy. The effect of discontinuing thiazide therapy on serum calcium and phosphorus levels may be helpful in assessing the need for parathyroid surgery in such patients. Parathyroidectomy has elicited subjective clinical improvement in most patients, but has no effect on hypertension. Thiazide therapy may be resumed after surgery.

Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. May affect insulin requirements in diabetics; may induce hyperglycemia and glycosuria in latent diabetics.

ADVERSE REACTIONS: Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, cholestasis, and pericholangiolitic hepatitis. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, transient blurred vision, sialadenitis, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have linked thiazides to pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. When adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn.

For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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Preoperative irradiation can reduce dissemination of mammary cancer cells.

Preoperative Irradiation of Breast Cancer*

Louis J. Sanfilippo, M.D./Livingston

Survival for cancer of the breast[12] has shown little improvement in the past three decades.[31] Conventional radical mastectomy still produces a five-year recurrence rate of 20 per cent in cases without node invasion, and close to 70 per cent when nodes are positive.[7] Failure occurs because cancer cells are disseminated prior to (or at the time of) surgery. Some evidence indicates that preoperative irradiation may prevent surgical dissemination, and improve results. Purpose of the report is to examine these data and suggest avenues for further study.

Surgical dissemination occurs when peripheral extensions of the tumor and natural barriers are cut across.[21] Tumor cells may also implant in the wound, or gain access to the lymph or vascular system through the cut ends of the vessels. Increased tissue pressure during surgical manipulation may force tumor cells into lymphatics or blood vessels or dislodge cells already there. Roberts[30] found that showers of tumor cells were released into the blood during operation in 9 per cent of 205 cases.

The incidence of vascular metastases was 39 per cent in those with circulating tumor cells at surgery and 18 per cent in those without. Survival at 5 to 10 years was significantly less in those with positive blood samples, 8 per cent versus 16 per cent, when no tumor cells were detected.

Preoperative irradiation may reduce the risk of surgical spread in several ways. It can destroy or inactivate tumor cells, eradicate peripheral tumor extensions, produce fibrosis of lymphatics,[13] and enhance local and general host immunity to tumor cell implantation. It may also augment surgery by destroying occult tumor extensions or lymph node metastases beyond the scope of resection.

Experimental Data

"Sublethal" doses (i.e. less than curative doses) appear to have profound effects on tumor and host. Several types of mouse tumors were irradiated *in vivo* with a sublethal dose of 2000 rads. Suspensions of the irradiated cells were injected 24 hours later into veins, subcutaneous tissues, and artificially produced wounds of other mice. The proportion of "takes" was reduced by 90 per cent compared with control mice given non-irradiated tumor cells.[17]

Single doses of 2000 rads preoperatively to Walker 256 Carcinosarcoma in rats (a third of "curative" dose) reduced the local recurrence rate[18] from 51 per cent with surgery alone, to 22 per cent. Surgical excision of C3H mouse mammary carcinomas produced local recurrences in 61 per cent at 100 days; only 41 per cent developed recurrence with 2000 rads and excision six days later. No significant decrease occurred, however, if surgery was performed one or 12 days after irradiation.[19]

Effects of pre- and postoperative irradiation on C3H mouse lymphosarcoma were compared to several dose levels. Cure rates were found to be superior with preoperative treatment, although the difference gradually di-

* From the Saint Barnabas Medical Center.

minished as the dose approached the curative dose of 3000 rads. Small doses were much more effective if given preoperatively. The "cure" rate with 500 rads was 77 per cent when given preoperatively, 44 per cent if given postoperatively, and 34 per cent with surgery alone.[27]

Results were thought to be inferior if surgery preceded irradiation because: (1) Edema and disturbed blood supply in the tumor bed reduced oxygen tension and lowered radiosensitivity; (2) Surgery disseminated tumor cells beyond the margins of irradiation; and (3) Surgery may have produced an immunologic derangement at the operative site due to a block of cellular or circulatory antibodies.

Irradiation of aerobic mammalian tumor cells *in vivo* and *in vitro* has demonstrated that sublethal doses of 500 to 2000 rads will reduce the viable cell population by 90 per cent, although much larger doses (in the range of 5000 to 7000 rads) are required for complete sterilization.[26]

Response to irradiation is not only affected by dose but also by the size of the tumor mass and degree of oxygenation. Suit[10] found that the sterilizing dose progressively diminished as the size of irradiated tumor nodules was reduced. A tumor nodule with 100,000 aerobic cells required 2380 rads for eradication,[10] in contrast to 1240 rads for a nodule with 100 cells. Well-oxygenated cells may be more radiosensitive by a factor as high as 2.8 compared with severely hypoxic cells.[1] Hence, small well-oxygenated tumor foci at the periphery of a mass or in lymphatics may be destroyed with doses below those required to sterilize the main tumor mass. This difference tends to diminish with fractionation of doses; as the tumor mass regresses, the oxygenation of tumor tissue improves.

Transplantation of tumor into host tissues is retarded by prior irradiation to the tumor bed. Single doses of 1500 to 3000 rads have been shown to suppress tumor "takes," probably by retardation of capillary "budding" and change in vascular function.[33]

Higher, necrotizing doses to tumors appear to affect general host resistance. In a recent study, 4000 rads x 1 given to allogeneic and isogeneic tumors in mice sustained the ability of the host to destroy small cancer implants. The incidence of lung metastases was nearly doubled when the tumor-bearing foot was amputated[3] compared with destruction by irradiation; 74 per cent versus 42 per cent.

Clinical Data

Generally, preoperative irradiation has been administered at three dose levels: low—2500 rads or less; moderate—3000 to 4000 rads; and high—5000 to 6000 rads. Low dose preoperative irradiation, given in large fractions of 400 to 500 rads, has been tried with apparent benefit in cancers of the esophagus,[24] bladder,[29] neck,[32] larynx,[16] and lung.[20] The only experience with low preoperative doses for breast cancer is that of Nakayama.[23] He administered single doses of 2000 rads to the breast and axilla and operated a few days later. He reported no untoward effects of irradiation and a two-year survival of 100 per cent in 30 patients.

Large clinical studies of breast cancer with higher dose levels of preoperative irradiation and greater fractionation have been conducted at three major centers in three different countries: The Anderson Hospital in Houston; the Toronto General Hospital and Toronto Cancer Institute; and the Institut Gustave Roussy in Paris. In these centers, preoperative radiotherapy encompassed the breast, chest wall, and regional lymphatics.

At the Anderson Hospital, preoperative irradiation has been tried prior to radical mastectomy for borderline operable and/or surgically disturbed tumors. Lesions are borderline operable when greater than 5 centimeters in diameter, with skin edema or fixation over the tumor only, or low or midlevel axillary nodes greater than 2 centimeters in diameter.[11]

Tumors with disturbed biopsy sites (hematomas, ecchymoses, infection) from open biopsies elsewhere were noted initially to have

chest wall recurrence of 33 per cent after radical mastectomy alone.[34] Preoperative irradiation with Cobalt 60 consisted of approximately 4000 rads in four weeks to the breast and chest wall. Lymphatics received 4000 rads to the mid-axilla, and 4500 rads to the internal mammary and supra- and infraclavicular nodes, given in five weeks.[9] Radical mastectomy was performed 5 to 6 weeks later. If surgery was delayed less than five weeks, the tissues were found to be quite vascular with increased blood loss. At 8 to 9 weeks, the tissues became adherent and difficult to separate.

No increased incidence in postoperative complications occurred. This was in contrast to a five-fold increase after preoperative irradiation of 3500 to 4000 rads with 250 kilovolts. Results were impressive. The ten-year survival rate of 335 patients was 61 per cent. The most significant increase was in patients with positive axillary nodes: 41 per cent compared with 23 per cent with radical mastectomy alone and 28 per cent with postoperative irradiation. Chest wall recurrence rate[34] was only 4.5 per cent.

In Toronto, preoperative irradiation has been the practice since the 1930's—in all stages, and combined with simple or radical mastectomy.[4] Most patients had locally advanced disease and received radical mastectomy. Preoperative doses, mostly given with a 400kV unit, were 4500 rads in four weeks. Here the over-all survival of 467 cases with preoperative irradiation was 35 per cent at 5 years and 18 per cent at 10 years, and was superior in those with radical mastectomy. Most of the cases correlated with the International TNM Stage III group. Survivals of 192 cases in this group treated with preoperative irradiation and radical mastectomy were 31 per cent at 5 years and 16 per cent at 10 years. The authors concluded that salvage was improved significantly by preoperative irradiation.

At the Institut Gustave Roussy, preoperative cobalt irradiation was given to patients in a clinical category with: tumor over 7 centimeters, skin involved with peau d'orange beyond the tumor, complete fixation to the pectoral muscle, or incomplete chest wall fixation.[5] Radiotherapy was given initially to the 242 cases in this group. Of these 152 subsequently underwent simple mastectomy (with or without axillary dissection) after receiving 4500 rads in one month. The remainder were treated with radiation alone because of local or general contraindications or refusal of patients to undergo surgery. Five-year results after preoperative irradiation and simple mastectomy were 39 per cent, compared with 12 per cent for radiotherapy alone.

Initial radiotherapy was also given to 35 patients with chest wall fixation. In only six did irradiation of 4500 rads in one month make surgery feasible. The five-year survival was similar in those with combined treatment or with radiotherapy alone, 17 per cent and 12 per cent respectively.

No significant studies have been conducted with high dose preoperative irradiation of breast cancer.

Radiosensitivity of Breast Cancer

Clinical studies indicate directly and indirectly that the tumor lethal dose has a wide range and is related to tumor size. Higher doses are required for large masses because they contain more cells and a greater fraction of hypoxic, or radioresistant, cells. Wedge resection and irradiation of 4500 rads in four weeks for early carcinomas has achieved a survival rate of 62 per cent free of disease from 3 to 20 years. The local recurrence rate was 11 per cent and only 5 per cent in lymphatics.[28] Lesions inoperable by triple biopsy criteria of Haagensen (many of which were over 5 centimeters in diameter) received 7000 rads to the primary site and 5000 rads to chest wall and lymphatics. The 5-year survival was 60 per cent and 10-year was 30 per cent, with sterilization of microscopic lymph node disease proved in a number of cases.[34] Even higher doses were tried to control more locally advanced disease, inoperable by Haagensen's clinical criteria. Doses of 7500 to 9000 rads in 9 to 10 weeks given to the primary tumor

produced a local recurrence rate of 22 per cent, with 27 per cent alive at five years and 10 per cent at ten years.[21]

Control of lymph node disease is similarly dependent on dose and tumor size. In a large randomized study, the incidence of supraclavicular metastases in cases with postoperative irradiation of 3250 rads in three weeks was reduced to 6 per cent, compared with 17 per cent in those without irradiation.[25] Fletcher[8] concluded from a review of a large series that 4500 rads/5 weeks can control 80 to 90 per cent of non-palpable lymph node disease (subclinical aggregation of cancer cells). Palpable axillary or supraclavicular nodes of moderate size are controlled in 90 per cent of cases with doses of 6000 to 7000 rads in 6 to 7 weeks.[9]

Protocol for Preoperative Irradiation

A suggested protocol for preoperative irradiation is listed in Table 1 and is similar to that recommended by Murphy.[22]

tolerated after 5000 rads to the chest wall and higher doses to the primary site through small ports.

Low dosage is advocated for early disease because it is probably sufficient to destroy or inactivate a large proportion of tumor cells and thereby prevent surgical dissemination. However, the intensity of the course, 2000 rads in 5 fractions in one week, make it biologically equivalent to 3000 rads in four weeks.[6] This is still considered sublethal; therefore, postoperative irradiation should be given to the peripheral lymphatics: 2000 rads in two weeks, when nodes are positive at surgery.

Progressively higher doses are recommended for larger more advanced primary tumors, and axillary node spread. The scheme for borderline operable lesions is the same as that of the Anderson Hospital. For locally advanced lesions of limited extent, more clinical data are needed to determine if they are best treated by 4500 rads and radical mastectomy,

Table I

Suggested Protocol for Preoperative Irradiation

Stage	Technic	Surgery
Early—Primary <5 cm. without extension. Palpable mobile axillary nodes <2.5 cm. D.	2000 rads in one week*	Immediate Radical Mastectomy
Borderline Operable		
Primary >5 cm. Skin edema or fixation over tumor only.	4000-4500 rads in one month	Radical Mastectomy in 5-6 weeks
Multiple low or midlevel mobile axillary nodes >2.5 cm. D.		
Locally Advanced		
A. Skin involvement beyond the tumor mass <½ breast.	4000-4500 rads in one month	Radical Mastectomy** in 5-6 weeks
	—or—	—or—
Fixation to pectoral muscle.	5000 rads/5 weeks +	Simple Mastectomy** in
Axillary nodes large, multiple or with limited fixation.	2000 rads to residual Ca	2-3 months
		—or—
		Radiotherapy alone
B. Skin involvement >½ breast.	5000 rads/5 weeks +	Radiotherapy alone
Chest wall fixation.	2000 rads to residual Ca	—or—
	—or—	Simple Mastectomy** in
Massive, fixed axillary nodes.	Rapid palliation	2-3 months

* Supplement with 2000 rads in 2 weeks post-operatively to peripheral lymphatics when nodes are + at surgery.

** If response is favorable, and the plane of surgical resection appears free of gross tumor.

Radical mastectomy is not advised after preoperative doses in excess of 4000 to 4500 rads. However, simple mastectomy should be well or 5000 rads plus 2000 rads to the primary site and simple mastectomy, or by radiotherapy alone.

Extensive locally advanced lesions may not be suitable for curative treatment and should be given palliative irradiation only. Selected cases may receive radical treatment with radiotherapy alone or combined with simple mastectomy if the lesion becomes resectable.

Summary

Little improvement in survival for breast cancer has occurred in the past thirty years. Experimental and clinical data have been presented to show that preoperative irradiation can reduce local dissemination at surgery and may prevent systemic spread as well. Further clinical investigation appears warranted. A protocol for preoperative irradiation according to clinical stage is suggested.

A bibliography of 34 citations will be found in the author's reprints.

44 Old Short Hills Road

Vaccines: A Success Story

Basic research in virology and immunology is paying off through enhanced ability to produce effective vaccines. Dr. Saul Krugman of the New York University School of Medicine devised two new vaccines against serum hepatitis. Active immunization prevented serum hepatitis in a small group of children innoculated; passive immunization with hepatitis B immune serum globulin was 70 per cent effective in the same study group. The vaccines are in short supply and perfection for general use may take several years.

Researchers at the University of Illinois have taken a giant step toward the development of a human vaccine against malaria. They protected rhesus monkeys against a form of malaria normally lethal to them. This is the first time a partially purified material isolated from malarial parasites has been used to protect primates. Current studies are narrowing down what actually is responsible for conferring protection.

The U.S. Public Health Service no longer recommends routine universal smallpox vaccination in the United States. This is the first time a disease as internationally widespread as smallpox has been brought under control.

There is another new vaccine in the making—for syphilis. Dr. James Miller of the UCLA School of Medicine reported that he and coworkers had successfully immunized rabbits against experimental syphilis. An apparent complete immunity was developed in the animal, he said, after administration of the vaccine over a 37-week period. The next step will be to reduce the time and quantity of dosages.

The first-year experience with rubella vaccine was highly successful. It gave protection from the disease with few side effects. Reported in the *Journal of the American Medical Association,* the summary said vaccination against rubella is the "best of the options currently available for preventing maternal fetal rubella."

A new triple vaccine against measles-mumps-rubella was approved by the Food and Drug Administration and found safe, simple, and effective. The particular advantage of the triple approach is that only one contact with a child is needed to confer protection against all three diseases—especially important in areas difficult to reach on more than one occasion.

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The glib diagnosis of organic brain involvement is, Dr. Gould thinks, too often made on cursory evidence, when the factors are largely emotional.

Learning and Impediments to Learning

Kenneth S. Gould, M.D./New Brunswick*

In the past few years much has been written about factors which prevent children from learning in an adequate manner. The more evident causes (such as serious emotional and neurologic problems) have long been recognized, but most of our new problems do not fit neatly within these categories. The child who has trouble reading, writing, spelling, or performing numerical tasks is more often the youngster whose performance cannot be diagnostically pigeonholed.

Recently, a new general classification has been suggested: the syndrome of cerebral dysfunction. Here postulated is an organic basis to the syndrome, and efforts have been made to demonstrate the organicity of the syndromes included within this broad category. These cover the hyperkinetic impulse disorder of which so much has been written recently. In this classification, an organic, intrinsically neurologic cause is suggested, residing within the diencephalon. Such a diencephalic disturbance, perhaps maturational, acts to prevent adequate filtering of incoming stimuli. As a result children with such a syndrome evidence poor concentration, great distractibility and greatly increased motility. Since the focus is believed in the mid-brain, these children are found to have normal intelligence. The condition is believed to disappear by adolescence, by which time the neural pathways have "matured." It is thought that administration of amphetamines and methylphenidate (Ritalin®) will, in a paradoxical manner, result in a child's increased ability to control and direct the flow of stimuli.

Case One

A six-year old youngster is considered by both the school, and his parents, to have many problems. His parents feel that he has poor coordination, that he is clumsy, with large feet and hands. He attended nursery school last year and was there considered to be very aggressive. The teacher felt he lacked dexterity. He had difficulty in learning to open the door latch. He cries easily, is considered emotional, and is unable to adjust to group situations.

During his first year in kindergarten he would, at times, crawl on his hands and knees. The teachers have felt his innate ability was normal, but that he had great difficulty in adjusting to school situations.

His gestation and delivery were considered to be normal. His growth rate was normal and the early months were characterized by the parents as "not unusual." At age four he was noted to be stammering. The mother described herself as always yelling and screaming at him. She feels that she is a perfectionistic person.

The clinical interviews with the child were noteworthy in many ways. Upon initially seeing the examiner he stood stiffly in the room. He appeared anxious and uncomfortable and moved mechanically. He tried water colors, using them without water. He drew crude, primitive circles and at times would walk in circles around the room. On occasion, he would become tearful and ask to see his father. He would frequently stammer and blush. During one interview he had his shoes on the wrong feet. Frequently he would use paints in a very crude manner, smearing them in wide circles. The stammering and blushing continued and there was frequent head cocking. At times he would show good neuromuscular coordination. At other times he had great difficulty in loading dart guns. Generally the clinical interviews were characterized by disturbances in psychomotor function, fine motor activity, autonomic nervous system function, and involvement of various ego functions.

Reports from the teacher indicated that he does well in reading and has improved a lot in school. He had previously exhibited temper tantrums but these have subsided recently. He is mischievous, there is difficulty in concentrating, and he is restless. At times he will pace back and forth. He runs rather than walk, and at times bangs into a wall. He will get upset at stressful situations and the teachers find it difficult to control him. Teachers have felt that his gross muscle co

* Dr. Gould is Associate Professor of Psychiatry at Rutgers Medical School (UMDNJ).

ordination is good as contrasted with small muscle movements.

As is so often the case with an "idea whose time has come," there has been a rush on the part of psychiatrists, psychologists, parents, and teachers to label all behavioral problems in school as having a neurologic basis. The terms "neurologically impaired," "cerebral dysfunction," "minimum brain damage," "perceptually impaired," "visual motor disturbance," and "hyperkinetic impulse disorder" have all become *de rigeur* within certain educational and psychological circles.

Despite the possible validity and wisdom involved in creating such new categories, I feel that *indiscriminate* labeling of children as neurologically impaired creates serious problems. Such labeling *without sufficient evidence* does a great disservice to all concerned: child, parents, and teacher. A diagnosis should be made only after painstaking and meticulous studies are done in order to understand, as well as possible, the dynamics and mechanisms involved in a specific child's inability to perform certain cognitive functions. Too often, a quick diagnosis is made and drugs are instituted, as if in some magical way a pill will "make everything all right."

Those of us in the field of child psychiatry do recognize that there are children who have intrinsic neurologic problems that profoundly affect their ego functions in the areas of psychomotor and cognitive development. The youngster who comes from a home where there is reportedly little or no emotional turmoil, where parental roles are reasonably well established, and where thorough psychologic history and examination does not elicit evidence for either intrapsychic or intrafamilial emotional conflict is a case in point. Such a child may have problems with learning which originate primarily within the central nervous system. At times a teacher will describe such a child in her report as "he tries so hard but he just can't do the work." Further reports from other teachers and school psychologists may suggest that they do not believe the emotional factors to be crucial in the learning disability. This type of report contrasts markedly with one dealing with a child whose problems seem to be primarily emotional in origin. Often the report by the teacher will state, "he can do the work but he just doesn't try."

In the psychiatric examination of a child having an intrinsic neurologic problem the clinician is often impressed with certain recurrent features. One such feature is seen where a child will attempt to impress the examiner in those areas of cognitive function where he feels most able.

Case Two

A ten-year old girl, from the parental history, school reports, and psychologicals, was considered to have a primary cerebral dysfunction manifesting as cognitive impairment. In the initial interview she seemed alert, friendly, and a very cooperative child. Superficially she appeared to have a fairly good self-image. Neuromuscular function was excellent. She ran, jumped, skipped, and caught a ball with facility. There was no evidence of abnormal psychomotor function. She showed the examiner her report cards, and said that she does poorly in mathematics and reading. She showed a great curiosity about animals and wants to be a veterinarian. She was able to recognize all the model animals, wolf, fox, cow, goat, and gorilla and took great pride in her ability to do so. During the interview she found it difficult to answer questions about arithmetic and reading. She freely reported trouble in those school subjects. She is in the same class as her younger sister and she feels that her sister does much better than she in certain school subjects.

The neurologic examination of children at times is helpful, but it must be evaluated carefully. The "soft neurologic signs" (for example, inability to throw a ball well, to run, jump, or do certain complicated tasks) will often be the result of anxiety. Allowing the child to relax, to test him at later times when he is more comfortable, will often cause the "soft signs" to disappear. Their continued presence in such cases lends added weight to the findings.

While the child with central nervous system dysfunction can sometimes be easily recognized, it has been my impression that the diagnosis is made too often without supporting evidence. To make such a diagnosis will require information derived from a detailed past history, encompassing prenatal, natal, and post-natal periods. There must be care-

fully conducted psychiatric and neurologic examinations and frequently psychologic and other examinations, such as electroencephalography must be done. A diagnosis made without sufficient clinical and historical evidence does a great disservice to the child. In large part the therapeutic approach is determined by the nature of the diagnostic entities. A diagnosis of cerebral dysfunction, presenting as the "hyperkinetic impulse disorder," might indicate the use of drug therapy, while an emotional disorder would call for primarily a psychotherapeutic approach. It has been the impression of this clinician that many cases of "hyperkinetic impulse disorder" and the so-called perceptual motor disturbances are primarily emotional in origin. Even when there is a combination of factors (both emotional and organic) as precise a diagnosis as possible will allow for sensible ordering of therapeutic priorities.

Conclusion

In brief then it is incumbent upon all those who are charged with the study of a child's learning impairment to establish as precise an evaluation as possible. Ego functions, neurologic functions, and dynamics of behavior should be carefully evaluated in order to plan for the most effective treatment.

Rutgers Medical School

Suicide Prevention and Crisis Intervention

The National Institute of Mental Health is now refocusing the activities of its Center for Studies of Suicide Prevention to reflect a more comprehensive crisis intervention program. NIMH, which is a component of HEW's Health Services and Mental Health Administration, established the Center in 1966. Now, the Center for Studies of Suicide Prevention will be abolished and replaced by a section on crisis and suicide problems, to focus on the program specifics of crisis intervention strategies and suicide-related problems.

"This new section," said Dr. James A. Goodman, Division Director, "will assume an advocacy role, within the Institute." In 1966, there were only a handful of suicide prevention centers in this country; today over a thousand local groups and organizations are working in the area of suicide prevention and crisis intervention. The section will engage in functions involving the stimulation, development, and support of research, and training projects will be available through the Division of Special Mental Health Programs.

FDA Approves Bone Cements

The Food and Drug Administration announces approval of new drug applications for Methyl, Methacrylate* for cementing in place total hip replacement prostheses. This approval makes available a significant new therapy for disabled patients. A number of such patients can now be at least partially rehabilitated through judicious use of this new material in orthopedic surgery. The drug will be available for restricted use as specified in the package insert. (The manufacturer will mail each orthopedic surgeon a copy of this insert.)

The Food and Drug Administration expresses appreciation to the American Academy of Orthopaedic Surgeons for help during the approval process. Special appreciation also is due the orthopedic surgeons who served on the FDA's Ad Hoc Advisory Committee. The FDA wishes to compliment the Academy on its current program to develop training courses in 23 centers to assist orthopedic surgeons in the proper use of this new drug.

—FDA Drug Bulletin

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Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

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Coronary care units are popular but here is one of the few efforts to follow up the results and measure the effectiveness of these installations.

Evaluating the Effectiveness of Coronary Care Units

Theodore H. Goldberg, M.D./Westwood*

For the past two years, the Coronary Care Committee of the New Jersey Heart Association has worked with 48 hospitals throughout New Jersey, collecting statistics on the effectiveness of coronary care units in reducing the mortality from acute myocardial infarction. The hospitals have varied from very small units in rural or suburban areas to large metropolitan hospitals. The cooperating hospitals have been provided with reporting forms for each unit which are forwarded to the heart association office, which then totals the results. To give adequate numbers, the total patient population represented by these 48 coronary care units has been grouped together. In this way, in a six-month period, a total of two to three thousand coronary care unit admissions with definite diagnosis of acute myocardial infarction has been accumulated. Criteria for definite myocardial infarction include a compatible clinical history, the development of diagnostic Q waves or evolution of S-T segment and T wave abnormalities on electrocardiograms, with characteristic changes of myocardial enzymes in serial blood samples. These are classified as Category A, and the classification is not determined until the time of discharge from the coronary care unit. Those patients with suggestive chest pain but non-specific alterations of the S-T segments and T wave changes in initial electrocardiograms, which, during hospitalization, progressed toward normal, and normal or non diagnostic variations in enzyme activity are classified as Group B. These are then eliminated from the calculation of statistics. The hospitals are asked to identify those patients in Category A that die in the coronary care unit from a primary arrhythmic cause, such as primary ventricular fibrillation or primary ventricular asystole, not complicating shock or congestive failure, or those who die from primary power failure (intractible shock or congestive failure), or those who die from other causes. The forms have been kept as simple as possible so that they may be completed by just checking off boxes. In most cases, they are completed by nurses or ward clerks who briefly question the physician at the time the patient is transferred from the coronary care unit or expires. A similar statistical program has been run in California among a group of 100 hospitals in 1970.† The number of cases is almost exactly double those from the 48 hospitals in New Jersey, and the information obtained, although more detailed, contains the same basic information as that collected in the New Jersey survey. Comparison of the two studies reveals striking similarity.

The New Jersey statistical program was initiated, not simply to collect statistics, but to meet certain specific objectives. First, it was an effort to measure the effectiveness of coronary care units in our state. It was our feeling that many units had no idea even as

*Chairman, Coronary Care Unit Committee, American Heart Association, New Jersey Affiliate

†Wyman, Milford G.: "Measuring and Improving the Effectiveness of the Coronary Care Unit in Community Hospitals." Abstracts, Third National Conference on Coronary Care Units, June 7, 8, 9, 1971 pp. 29-32

Table I

48 Cooperating Hospitals Reporting

	Total Patients Group A	CCU Mortality	Ventric. Fib.	Asystole	Power Failure
N.J. Jan.-June 1970	2271	13.1%	62	68	224
N.J. Jan.-June 1971	2783	14.3%	75	70	198
California Study (Jan. 1970-Jan. 1971 100 Hospitals)	5946	13.8%	126	149	Not available

to how many patients they handled, much less as to the reduction in mortality or morbidity. The second purpose was to help units evaluate themselves and upgrade their care accordingly. The third objective was to pinpoint unsolved problems in coronary care, and the fourth was to enable the hospitals themselves, (as well as our survey) to follow up patients discharged from the coronary care unit and find out what their fate was in the remainder of their hospital stay.

As shown in Table I, the mortality statistics in the New Jersey group exhibited a striking similarity to the mortality in the California Study. In New Jersey, from January to June 1970, there were 2,271 patients with a 13.1 per cent mortality. From January to June 1971, there were 2,783 patients with a 14.3 per cent mortality. In California, from January 1970 to January 1971, there were 5,946 patients with a 13.8 per cent mortality. In all three groups, there were a significant number of patients who died from primary ventricular fibrillation. As a matter of fact, the number was roughly equal to those who died from primary asystole. The number who died of power failure was more than those dying of ventricular fibrillation and asystole combined. Power failure, then, remains the single most important cause of death in the coronary care unit. The information on patients dying in the hospital after transfer from the coronary care unit is somewhat sketchy. It probably does not approach the degree of accuracy, at least in the New Jersey study, of the mortality information for patients in the coronary care unit. However, it is striking that the ratios, in both studies, of total deaths is roughly similar. (Table II) In the New Jersey study, 17.7 per cent of the total deaths occurred after transfer from the coronary care unit. This gave a mortality of patients leaving the unit of 3.7 per cent. In the California study, 22.2 per cent of the total deaths occurred after transfer from the coronary care unit. In the New Jersey study, most of the deaths following transfer occurred up to the 14th day, although a substantial number occurred in the third week and thereafter.

Table II

Deaths after Transfer

	Per-cent of Total Deaths	Mortality of Patients Leaving C.C.U.
New Jersey Study	17.7 (88 patients)	3.7%
California Study	22.2 (181 patients)	

To summarize the results, the mortality rate in coronary care units of "Class A" coronaries is stable at 13 to 14 per cent over a two year period of observation. A significant number of deaths due to primary ventricular fibrillation and primary ventricular asystole continue to occur. In the case of ventricular fibrillation, this is of special interest, because many writers have indicated that this should no longer be a cause of death in the coronary care unit. However, the data suggest that in spite of well-functioning coronary care units, there still are some cases resistant to therapy as it is currently used. Primary power failure remains the major single cause of death. Approximately 20 per cent of in-hospital deaths occur after discharge from the coronary care unit.

On the basis of these findings, it is recommended that further improvement in mortality can only be obtained by the following:

(1) Detailed analysis of patients dying of primary ventricular fibrillation or asystole in an

effort to determine which cases are predictable and/or preventable.

(2) Further efforts at treatment of power failure are necessary, perhaps through regional centers specializing in this problem.

(3) More detailed analysis of patients dying following discharge from the coronary care unit, and especially as to whether monitoring is an effective tool in the prevention of these post-CCU deaths.

The author expresses his gratitude to Mrs. Barbara Jordan, of the New Jersey Heart Association office, who aided in the collection of the statistics, and Dr. Lucian Fletcher, former chairman of the coronary care unit of the New Jersey Heart Association, who aided in the preparation of the questionnaires and the evaluation of the statistics.

336 Westwood Avenue

Mass Screening for Hereditary Diseases

Mass screening to detect certain hereditary diseases is rapidly becoming widespread. The aim of such programs is to reduce the number of affected children born by testing and advising parents what chance a child of theirs would have of inheriting the disease.

Testing for sickle-cell anemia became possible this year with the perfection of a simple, inexpensive, accurate test. The test, devised by Dr. Paul Wolf of Stanford University and Dr. Robert Nalbandian of Grand Rapids, Michigan, does not distinguish between those who merely carry a defective gene and those actually affected by the disease, but it does provide a fast method of locating those who need further attention. A new automated screening technic tested by Dr. Nalbandian now processes specimens at the rate of 120 per hour.

An estimated 2,000,000 black Americans carry one defective gene for sickle-cell anemia, but usually show no symptoms of the disease. The one child in 500 who inherits a defective gene from each parent is likely to die before his 20th birthday, or to be crippled if he lives to middle age. The only way to prevent sickle-cell anemia, if both partners carry the trait, is to avoid having children.

Tay-Sachs disease, affecting Jews of eastern European descent (over 90 per cent of American Jews), can also be detected by testing. About one American Jew in 30 is a carrier, and each year 100 to 200 children are born with the invariably fatal disease.

Couples in which both the man and woman are carriers of Tay-Sachs do have one more option than partners who carry defective genes for sickle-cell anemia. They can try to have children because available tests can detect, early in pregnancy, if the child is diseased and give the mother a chance to have an abortion. There are no such tests for detecting sickle-cell anemia in the fetus.

Multiphasic health testing is gaining wide popularity. About 130 centers are now operating in the United States. The procedure usually involves the taking of a scrupulous history, an electrocardiogram; a chest x-ray; mammography for women over 48; measurements of pulse, blood pressure, and Achilles reflex; tests of lung function, visual acuity and hearing; and height and body measurements. Blood and urine samples are also tested.

Continued advances in the field of radioisotope scanning for diagnostic purposes have been made possible by the development of new radio-pharmaceuticals or radioactive drugs, and more sensitive detection instruments. Experts predict that nuclear medicine procedures will soon approach the number of procedures performed by x-ray.

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Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

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Surgery does have something to offer in hand disabilities due to rheumatoid arthritis.

Reconstruction of Rheumatoid Hands

Jerome Spivack, M.D./Irvington

Reconstruction of rheumatoid hand deformities has been done for many years. Progress has been made in treatment of deformities of the wrist and metacarpal phalangeal joints. Arthoplasty, arthrodesis, tendon transfers, and synovectomies have helped rehabilitate many severely deformed and weakened hands. When the rheumatoid deformity is combined with a marked spasticity of the hand, the disability becomes magnified. Surgical correction is more difficult and the ultimate result is less optimistic.

Case Report

A 37-year old woman was referred because of severe rheumatoid arthritis in both hands and marked spasticity of the right hand and leg. In 1953, she had a severe cerebral vascular accident with a resultant right hemiplegia and aphasia. She was pregnant at the time and 3 months later had a stillborn baby. During the next six months the patient was retrained to walk, though she had marked spasticity.

In 1956 she began to notice swelling of the hands. Since then, swelling has involved most of the joints of the arms and legs. She was diagnosed as having either rheumatoid arthritis or lupus erythematosis.

She had had surgery for a tubal pregnancy in 1965. The patient had allergies to penicillin and sulfa drugs. She was taking Tylenol®, Tofranil®, Librium® and Maalox®. She had made several suicide attempts because of severe depression. Her husband frequently beat her. She felt she could not leave him, because she would be unable to provide for herself if she were alone.

She was a well developed, thin 37-year old female, who spoke with a slight slur. She had mild rheumatoid deformities of both knees and feet. There were marked deformities of the metacarpophalangeal and proximal interphalangeal joints with marked ulnar deviation of the fingers. The left wrist produced a painful popping noise on flexion and extension. There was a dislocation of the carpal-metacarpal joint of the left thumb. She had marked ulnar deviation of the proximal interphalangeal joint of the left index finger, with mild swelling and deformity of the proximal interphalangeal joints of the third, fourth, and fifth fingers. (See figures 1 and 2.)

The right upper extremity showed marked spasm of the fingers and wrist and moderate spasm of the elbow. She had hyperextension of the MP joint of the thumb, with marked dislocation of the carpal-metacarpal joint. Traction on the thumb produced a painful grinding sensation at the carpometacarpal joint. There was severe ulnar deviation of the second through the fifth MP joints, especially the fifth. A good passive range of motion of the MP joints and the PIP points was possible once the severe spasm and ulnar deviation were overcome. The distal end of the right ulna was dislocated.

Laboratory studies, prior to surgery, revealed normal chest x-ray, blood count, and urinalysis. Electro-



Figure 1—Flexion of fingers of the right hand, preoperatively.



Figure 2—Attempted extension of fingers of the right hand, pre-operatively.



Figure 3—Pre-operative x-rays of both hands.



Figure 4—Flexion of fingers of the right hand, three months post operatively.



Figure 5—Extension of fingers of the right hand, three months post operatively.

cardiogram showed an abnormal, nonspecific ST change, which on further evaluation was found to be a normal variant. X-rays of the hands (see figure 3) demonstrated the severe deformity described in the physical examination. X-rays of the feet and knees showed moderate osteoporosis, with a severe halux valgus deformity of the feet.

Surgery consisted of a release of the flexor pronator muscle group of the right forearm to reduce the spasticity. The distal ulna was resected to correct the dislocation and the pain associated with wrist flexion and extension. The thumb carpal-metacarpal joint was fused in a functional position and the MP joint of the right thumb was corrected by plication of the volar plate. Synovectomies of the metacarpal phalangeal joints of all the fingers were performed. Extensor tendons of the second through the fifth fingers were repositioned. The extensor indices proprius and the extensor digit quinti were transferred to the radial side of the extensor hood of the second and fifth fingers. The intrinsic muscles on the ulnar side of each finger were released to help correct the severe ulnar deviation. Two K wires were placed across the carpal-metacarpal joint of the thumb and the hand was immobilized in a bulky dressing and a plaster splint.

The splint was removed three weeks post-operatively and a short arm cast was applied with the wrist in mild extension. The patient gradually was able to flex and extend the fingers. For six weeks following removal of the splint, the patient had extreme weakness of extension of the fingers and wrist. This was related to the severe long term flexor spasms which resulted in stretching and atrophy of the extensor musculature. With time, the patient regained use of the long finger extensors, and later the wrist extensors. She had constantly increasing strength in the hand, and was able to take care of her own needs. (See figures 4 and 5.) The patient was delighted with the procedure and was anxious to complete surgery on the left hand which would be a straight forward procedure for the rheumatoid hand.

The treatment of spasticity by release of the flexor pronator muscle group is not a new procedure. Recent articles[1, 2, 3] have described this and have found it useful in selected cases. It is important that a careful examination determine that spasticity is the major problem. If the muscle tendon units are shortened or the joints are contracted, then the flexor pronator slide will be of little benefit. One complication[3] is a loss of pronation occasionally when the released muscle mass has migrated five centimeters or more distally. This is avoided by post-operative splinting in a neutral position.

Surgical care of the rheumatoid hand depends on the stage of the disease. In the patient described above, the wrist joint was only mildly involved. The distal ulna was dislocated and caused pain and limitation of extension when the spasticity was passively overcome. The ulna could be passively reduced. This distal portion was resected, the Darrach procedure. The radiocarpal joint was explored and was relatively normal and a small amount of synovium was removed. The extensor tendons appeared to be intact and there was no evidence of synovitis of the dorsal tendon sheaths.

In early involvement of the wrist joint and

the dorsal tendon sheaths, synovectomy alone may be sufficient.[4, 5, 6, 7] Linschield[5] performed imbrication of the dorsal radioulnar and dorsal radiocarpal ligaments to reseat the distal ulna in early cases. In more advanced cases, he resected the distal ulna. Kessler and Vainio[4] found less progression of the disease process in cases with synovitis and bony involvement by doing synovectomy and arthrodesis of the wrist when the radial and common extensor compartments were involved. If the ulnar compartment was involved, they performed synovectomy and resection of the distal ulna. Others[6, 7, 8] also favored arthrodesis of the wrist with severe involvement with loss of motion and severe pain. Some hand surgeons[9] prefer arthroplasty of the wrist joint. They found that pain was reduced, the wrist remained stable, and motion was maintained.

Arthrograms of the wrist joint have demonstrated changes which would have never been detected clinically until wrist joint destruction was advanced. One series[10] noted that the interosseous ligaments and articular discs were often destroyed as early as six months after the onset of the disease. This soft tissue involvement was an important cause of volar dislocation of the wrist, dorsal subluxation of the ulna, and tendon ruptures. If early synovectomies were carried out, the later need for arthroplasties and arthrodesis might be largely eliminated.

The metacarpophalangeal joints in our patient were markedly ulnar deviated with mild subluxation. Synovectomies of these joints were performed. The ulnar intrinsics and hypothenar muscles were divided and the extensor indicis proprius and extensor digiti quinti were transferred to the radial side of the index and little fingers respectively. The extensor digitorum communis tendons were repositioned.

These procedures[5] are the ones advocated for the mild to moderate deformity.[11] In the more severe deformity with marked subluxation or dislocation of the metacarpophalangeal joint and marked shortening of the intrinsic muscles, resection of the metacarpal heads[8] used to be the procedure of choice.[5] The use of Teflon prothesis[8] and the Flatt prothesis[12] to replace the metacarpophalangeal joints has produced fair results. Swanson silastic implants[13] have been very promising. Swanson stated that the results are far superior to their previous experience with other technics of joint arthroplasty.

Our patient's last major problem involved the thumb with destruction and dislocation of the carpal-metacarpal joint and secondary hyperextension of the MP joint. The carpal-metacarpal joint was fused and the volar plate of the MP joint was plicated. Linscheid[5] prefers to do a synovectomy and imbrication of the carpal-metacarpal joint of the thumb; or he may remove the greater multangular. For the MP joint, he could either reconstruct it or fuse it. Severe involvement of the IP joint would best be treated by fusion. Swanson[13] recommends fusion of the MP joints, if the carpal-metacarpal joint is adequate, since it requires good lateral stability in a power pinch.

Other common problems include volar tenosynovitis, tendon ruptures, and various deformities of the proximal interphalangeal joints. Volar tenosynovitis will frequently present as a carpal tunnel syndrome, swelling of the volar aspect of the wrist or progressive loss of finger flexion. Surgery consists of complete release of the carpal tunnel and synovectomy. Flexor tendon ruptures have been caused by attrition from small bony spurs in the carpal tunnel.[14] Ranawat and Straub[15] had 83 per cent good and satisfactory results in a series of 52 patients with volar tenosynovitis.

Extensor tendon ruptures are more frequent then the flexor tendons. Repairs are usually carried out at the same time as the other reconstructive procedures. The extensor communis can be repaired by suturing to an adjacent normal tendon[6], by tendon transfers, by tendon grafts, or by a combination, if more than one tendon is ruptured.[7]

The proximal interphalangeal joints may be involved and in early cases, synovectomy may be done.[5, 16, 17] Central slip reconstruction may be necessary at the same time.[5] Performed early, this procedure will reduce the pain and maintain function of the joint.[17] With destruction of the central slip, the PIP joint will develop the typical boutonniere deformity. Treatment may involve merely dividing the extensor tendon distally. In more advanced cases with a good joint, one may do the Littler procedure[18] of transferring the lateral bands to reconstruct the central slip. Heywood[19] described a technic in which the central slip is reconstructed and the ulnar lateral band is divided distally and weaved more proximally through the radial lateral band. In advanced cases with fixed joint deformity, arthrodesis is the best treatment.

The "Swan neck deformity" of the PIP joints may be corrected by reefing the volar plate and tenodesis of one slip of the flexor digitorum sublimis to the tendon sheath, if the joint has a normal range of motion. At times, this is caused by the subluxation or dislocation of the MP joints and arthroplasty of the latter joint will correct this deformity of the PIP joint. In certain patients the problems are more complex and require release of the ulnar intrinsics and dynamic splinting.[16]

Summary

A case of severe spasticity due to an old cerebral vascular accident, complicated by moderate rheumatoid deformities of the hand and wrist is presented. The surgical management is discussed and a brief review of the current literature is presented. Early surgical management of patients with rheumatoid deformities of the hands will produce better over-all results with less complex surgical procedures.

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40 Union Avenue

Special Article

The physician has a serious and nontransferable responsibility in this area. Here is a guide to the problem.

Medical Management of Child Abuse*

Purpose of this Guide is to alert the physician to his moral, professional, and legal responsibilities in the area of child abuse, to review the general problem of "the battered child," and to offer suggestions about proper management.

Our subject is defined as: "Non-accidental physical or mental injury inflicted on children by persons caring for them" (N.J. Law, Title 9, Chapter 6). The following references will be helpful: Fontana's articles in the March 1971 *Hospital Medicine, The Battered Child* (Helfer and Kempe 1968), *Wednesday's Children* (Young 1973), *Helping the Battered Child and Family* (Helfer 1972), and the article on the subject in the October 1969 issue of *Hospital Practice.*

In Colorado General Hospital the rate of battered children seen was five per week, 15 per cent of all children in ER under age 3. Fontana estimates that 10,000 to 15,000 children were severely injured in 1966; 25 to 30 per cent were permanently injured, and 5 per cent killed. A report from Chicago in the *Medical Tribune* states 1 of 2 children returned home will die (usually within a few months).

Slightly more males than females are injured. All races and religions are involved. Some 70 per cent are under the age of three and 32 per cent are under 6 months.

Perpetrators are most often in their 20's, usually they are parents or parent-surrogates. Most of the perpetrators are married and may be stable by first appearance. Socioeconomic status covers *all* groups.

Recognition of the Battered Child

Suspicions on Examination: Look for abrasions, contusions, bruises, burns, injured viscera, or fractures. If multiple and in different stages of healing, suspicion is aroused. Subdural hematoma is very suspicious. Also suspect is failure to thrive or severe malnutrition. Careful complete examination is necessary with thoughtful write-up.

Clues in History: Injury doesn't fit history. X-ray shows more than one fracture but only one is reported. The mother says he "bruises easily" and he doesn't. The mother says he is irritable or retarded and he isn't. Past medical attention includes many different physicians and facilities. A report of previously suspected abuse in any child may be found in the Central Registry of the Bureau of Children's Services in Trenton.

Suggested studies include: X-ray of long bones, ribs, and skull. Also consider blood coagulation studies (PTT), photograph of the child and injured parts (preferably in color). Request police help if needed. Admit child overnight to a hospital in any suspicious or suspected case. Remember that protection of the child is the over-riding goal of initial intervention.

The Abusing Parent

Frequently encountered traits include these: Usually they have been raised in same style. Either beaten or "intense, pervasive, continuous demands from their parents." They themselves have lacked "mothering." The child's performance is usually inadequate to the parents who may have unreasonable demands or unrealistic expectations.

There is a sense of rightness and righteousness on part of the parent; severe discipline is

* (Prepared by the Special Committee on Child Health of The Medical Society of New Jersey)

common. They believe the children are there to fulfill their needs. These parents are unhappy, frightened, isolated and/or deprived. They possess low thresholds of tolerance or frustration. However, there is no absolutely "typical" abusing parent.

Other factors within the family include periods of unrelieved emotional stress, chronic physical or mental illness, alcoholism or drug use, financial crises, and family disruption.

They can batter their children and yet bring them to the hospital. The children often remain loyal to the parents and feel they deserve the beating.

Handling of Parents: At the initial encounter, do not be angry with them; they are disturbed people who need help. They will become alientated and non-cooperative by anger. Many *want* to leave the child. They are afraid of themselves. Suggested statement: "The case appears somewhat complicated, we'd like to study it a bit more in the hospital."

Show parents you want to help them. Assure them your actions are not punitive—only to protect the child until the situation is corrected. Parents are more willing to accept therapy later if handled well initially.

Long-Term Therapy: The most important thing is to select the proper time for the child to return to the home. If too soon, the battering will continue. The parents need someone to "mother" *them,* (social worker, homemaker, etc.) Frequent home visits are desirable. Let the parents really lean on them, be available and concerned and sympathetic.

The State Bureau of Children's Services* is the type of agency to handle this. Never terminate support. Always be available for counseling within the limits of one's ability. Obtain psychiatric help if necessary.

Reporting

Initial Procedures:

1. Immediately call upon your local social service or hospital worker for assistance if available.

2. Any case of suspected child abuse must be reported promptly by phone to the Bureau of Children's Services* (the B.C.S. maintains in each district a 24-hour emergency telephone service).**

3. The physician's report should include information needed to identify the child, parents, and/or perpetrator where possible, as well as specific findings and reasons for suspecting maltreatment.

4. If urgent or necessary to insure the safety of the child, assistance from law enforcement officials may be requested through the Bureau of Children's Services.

Recommended Terms in the Physician's Report Might Include: "Not explainable by the available medical history as being accidental in nature;" "x-ray studies have shown no cause for this child to get fractures easily;" hematologic studies have shown no cause for this child to bruise readily;" "there is no apparent medical explanation for such severe malnutrition, fractures, and bruises other than neglect, abuse, or physical attack;" or, if true, when the child was asked how she was injured, she replied, 'my mommy did it.'" Physician's responsibility is not to fix guilt but to report findings.

Good medical testimony is essential to the protection of the child and proper legal proceedings in these cases. Therefore, physicians are urged to cooperate by appearing in court as requested. This is supported by the MSNJ.

Present New Jersey State Law is N.J. Stat. Ann. Secs. 9:6-1 to 9:6-8.7. It applies to children under 18.

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* 831 Parkway Avenue, Trenton—phone (609) 292-4245

** (800) 452-9150.

Who reports: Any person (having reasonable cause to suspect) must report any act of abuse, abandonment, cruelty, or neglect which results in serious physical or mental injury by other than accidental means by a parent, guardian, or person having custody or control of the child.

To Whom Reported: The Bureau of Children's Services.

Immunity: Unqualified.

Failure to report labels the individual as a "disorderly person."

Acknowledgment is made to the Child Health Committee of the Bergen County Medical Society for the initial guide and its efforts in behalf of abused children.

Peptic Ulcer: The Quiet Epidemic

Contrary to what many people think, the "high-salaried, eastern-big-city, businessman-executive" is not the typical peptic ulcer victim. True, he could have an ulcer, but so can all kinds of people of all ages, in urban and in rural areas. Even babies can suffer from ulcers.

Peptic ulcer—which attacks 4,000 new victims a day—seems to be on the increase. In *Peptic Ulcer—The Quiet Epidemic,* a new Public Affairs Pamphlet, Theodore Berland explains what a peptic ulcer is, how it is made, and who is most likely to get it. He describes the symptoms, how the diagnosis is made, the treatment, and how to keep an ulcer from returning.

In general, Berland points out, "people who get ulcers have an inherent susceptibility to them; and this susceptibility makes them particularly vulnerable to certain conditions in their environment. Stress is the primary environmental factor connected with ulcers."

Many doctors, Berland finds, agree that the hospital is the best place for treatment—if the patient can afford it—because there they have "complete control of the patient and his environment." There the treatment is likely to be diet, drugs, and sedation—with the aim of keeping the body and the emotions calm and the stomach secreting less acid.

Berland describes the different kinds of surgery for different situations. But most doctors follow Dr. William Mayo's advice: "An ulcer patient should not be operated on until he experiences nine failures in medical treatment (rest, diet, and drugs)."

Ulcer patients are known to be unduly rough on themselves. To help them keep the ulcer from recurring, Berland suggests these rules to live by:

(1) eat and drink in moderation, (2) don't smoke, (3) if you can't do something about a situation, stop worrying, (4) if you can do something about it, do it, or ask George to do it, (5) don't bottle up your feelings—blow your top occasionally, (6) get away from it all—leave your work behind at your office—get away on holidays and vacations as often as you can, (7) make realistic schedules for doing things, seeing people, and getting from place to place, (8) Enjoy your life and your family and friends.

Peptic Ulcer—The Quiet Epidemic is No. 472 in the Public Affairs Pamphlet series, now in its 36th year. The series includes many other helpful titles covering health and science, family relations, social and economic problems, race relations. All pamphlets sell for 25 cents each; a list is available on request from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

NEW JERSEY DOCTORS' NOTEBOOK

Address of Retiring President*

E. Vernon Davis, M.D.

Often in the midst of the year's demanding activities I was weighed down with the feeling that the term of office might prove crushingly long. Now as it comes to its end, I find in retrospect that it has seemed amazingly brief. For me, as for every president of the Society I am sure, the experience of serving as president has been challenging, interesting, instructive, and encouraging. I have learned to perceive, as I never did before, how many, diversified, and complex are the areas with which, as a Society and as individual members of the profession, we must concern ourselves. I have been awed by the far-reaching significance of the decisions which we are called upon to make.

No longer can a physician conceive that his is a simple, direct relationship and responsibility between himself and his patient. Now his daily decisions and activities affect not only his patient's health and welfare, but they influence the spirit and temper of contemporary society, the attitude and actions of government, and basic factors bearing upon the stability and balance of our national economy.

That is why every member of our profession must do his or her conscientious best, as a physician and as a member of contemporary society, to protect the health and welfare of patients, but, beyond that, to preserve and foster the over-all best interests of the nation as a whole.

In our efforts to acquit ourselves of this responsibility, we must be neither too polite nor too indifferent to enter into sharp and vigorous disagreement with any and all who, with confidence in their own unproved judgments, attempt to lay down rigid, arbitrary, and sometimes crippling regulations for the deliverers of health care services to follow. We must be vigorous in pressing for the retention or adoption of every practice, proposal, or idea that we see as constructive and good in its impact. We must be equally vigorous in opposing retention or adoption of every practice, proposal, or idea that we see as destructive and bad.

To carry out this objective, we must act firmly on the basis of our convictions as individuals, but especially we must, through our organized strength in medicine, act vigorously and unitedly as a profession.

That is what we in the Medical Society are trying to do. That is why, with such impressive generosity, all our officers, council and committee members, and staff give so constantly of their time and energies.

The reports that are before the House of Delegates and that will be made available to all our members in the Transactions issue of *The Journal* offer the chronicle of this year's undertakings and achievements. I commend them to your reading, and I exhort you, if you have not already so committed yourselves, to realize now that *your* help is needed, and to make a firm resolve to give that help to your utmost.

I am retiring from the command post, and a new leader is to succeed me. To Doctor D'Elia I pledge every assistance that I can render in any capacity, as I do to all of you. We of the profession of medicine are the preservers and defenders of life. Let it be said of us that in these times of indecision, we supplied leadership and service that gave new life and lustre not only to our profession but to all the American people as well.

* Delivered before the 1972 House of Delegates, MSNJ, second session, May 7, 1972, Atlantic City.

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- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe—day or night—even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

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brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used wi caution in patients about to undergo surgery of the biliary trac

Patients Receiving Narcotics. Talwin is a mild narcotic antagonis Some patients previously receiving narcotics have experienced mi withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administere to patients prone to seizures; seizures have occurred in a few suc patients in association with the use of Talwin although no cause ar effect relationship has been established.

Adverse Reactions: Reactions reported after oral administratio of Talwin include *gastrointestinal:* nausea, vomiting; infrequentl constipation; and rarely abdominal distress, anorexia, diarrhe *CNS effects:* dizziness, lightheadedness, sedation, euphoria, hea ache; infrequently weakness, disturbed dreams, insomnia, syncop visual blurring and focusing difficulty, hallucinations (see *Acu CNS Manifestations* under WARNINGS); and rarely tremor, irr tability, excitement, tinnitus. *Autonomic:* sweating; infrequentl flushing; and rarely chills. *Allergic:* infrequently rash; and rarel urticaria, edema of the face. *Cardiovascular:* infrequently decreas in blood pressure, tachycardia. *Other:* rarely respiratory depressior urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose i 1 tablet (50 mg.) every three or four hours. This may be increase to 2 tablets (100 mg.) when needed. Total daily dosage should no exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addi tion to analgesia, aspirin can be administered concomitantly witl Talwin.

Children Under 12 Years of Age. Since clinical experience in chil dren under 12 years of age is limited, administration of Talwin i this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have receive Talwin orally for prolonged periods have not experienced with drawal symptoms even when administration was abruptly discon tinued (see WARNINGS). No tolerance to the analgesic effect ha been observed. Laboratory tests of blood and urine and of liver an kidney function have revealed no significant abnormalities afte prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin over dosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and othe supportive measures should be employed as indicated. Assisted o controlled ventilation should also be considered. Although nalor phine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, par enteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, par enteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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Trustees' Minutes

April 16, 1972

A regular meeting of the Board of Trustees was held on April 16, 1972, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Jerome G. Kaufman, M.D. . . . Observed a moment of silent prayer in tribute to the memory of Dr. Jerome G. Kaufman, 171st President of MSNJ, who died on April 1, 1972.

. . . Adopted the following memorial resolution and authorized a memorial contribution to the Medical Student Loan Fund in memory of Dr. Kaufman:

JEROME GEORGE KAUFMAN, M.D.
1901—1972

Whereas, after a rich life of distinguished and exemplary service as a renowned physician and outstanding medical leader, Jerome George Kaufman, M.D., our beloved colleague, has been called to his eternal reward; and

Whereas, as President, member of the Board of Trustees, Chairman of the Committee on Annual Meeting, member of numerous councils and committees, and Delegate to the American Medical Association, Doctor Kaufman uniformly rendered high and valuable services to The Medical Society of New Jersey and to the people of our State; and

Whereas, his generous spirit led him to give further of himself as member and President of the State Board of Medical Examiners and as an active worker in many spheres of community and governmental health-care concerns; and

Whereas, by his indefatigable industry he commanded esteem and by his quiet amiability he won the affections of all with whom he came in contact; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Jerome George Kaufman, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow in token of heartfelt sympathy.

Membership for Interns and Residents . . . Voted to record itself as approving the creation of a category of membership for interns and residents in MSNJ.

. . . Directed that Legal Counsel study the Society's Charter to ascertain whether any of its provisions would interfere with the creation of such a category of membership.

. . . Directed that the results be made available to the members of Reference Committee "A" and to the officers and delegates appearing at the hearings of that committee.

Emergency Medical Services Seminar . . . Authorized the Chairman of the Committee on Emergency Medical Care to attend (with expenses paid) a seminar on emergency medical services in Baltimore, May 16 and 17.

New Jersey State Nurses' Association . . . Authorized the Executive Committee, and those members of the Board of Trustees who wish to participate, to accept the invitation to attend, as official representatives of MSNJ, a meeting of the Board of Directors of the New Jersey State Nurses' Association to consider a recommendation from the National Commission for the Study of Nursing and Nursing Education concerning the congruent roles of the physician and the nurse in providing quality health care.

CMDNJ—Annual Report . . . Directed that Stanley S. Bergen, Jr., M.D., President, CMDNJ, be informed that the Society would welcome a written annual report reviewing the activities, goals, aspirations, and problems of the College for distribution to the House of Delegates.

Current State Legislation . . . Approved the following positions on current legislation recommended by the Council on Legislation except as indicated.

All measures thus marked (*) are identical with bills of last year—or preceding years—whose official positions were the same.

S-576 —To provide that no person, partnership or corporation shall sell any packaged foods in this State unless there is affixed thereto a label stating every ingredient in order of its predominance. *APPROVED*

*S-597 —To authorize the Commissioner of Health to provide for the care and treatment of drug addicts by public and private facilities, including out-patient care and rehabilitation treatment and to appropriate $300,000. *APPROVED*

*S-605 —To provide that no person shall store or drain or dispose of dangerous or toxic chemicals in or on the soil unless the soil is protected by a dike or shield and unless an annual permit is obtained from the Commissioner of Environmental Protection. *APPROVED*

*S-606 —To create the New Jersey Medical Education Loan Fund in the Department of Higher Education. *APPROVED*

*S-607 —To authorize the Public Utilities Commission to regulate and control radioactive material, waste and by-product material and to provide for licensing and filing of annual reports. *DISAPPROVED*, because it is unnecessary and would conflict with the Department of Environmental Protection.

*S-613 —To create a guaranteed medical education loan program within the Higher Education Assistance Authority and to appropriate $50,000. *APPROVED*

S-622 —To grant any counselor, psychologist, nurse, or other staff member of a non-profit youth organization immunity from civil suit for damages in actions arising from efforts to help persons cure their dependency on or from the illegal use of controlled dangerous substances. *APPROVED*

S-630 —To provide that no person shall operate a motor vehicle while in possession of a controlled dangerous substance. *APPROVED*

S-631 —To provide that no person shall operate a motor vehicle while under the influence of a controlled dangerous substance. *APPROVED*

S-639 —To transfer functions, powers and duties of professional boards to the Director of the Division of Consumer Affairs in the Department of Law and Public Safety. *DISAPPROVED*, because the personnel of the State Board of Medical Examiners are better qualified to pass upon the basis of suspending or revoking a physician's or surgeon's license, especially in arriving at determinations of physical and/or mental incapacitation or determinations concerning the standards of competent medical practices. The bill would place professional boards in the anomalous position of having the sole right to grant licenses which another agency has the sole right to suspend or revoke.

S-640 —To provide that no renewal certificates of registration shall be issued by the Board of Pharmacy following approval of this act until the applicant submits satisfactory proof to the Board that he has participated in courses of continuing professional pharmaceutical education of the types and number of credits specified. *NO ACTION*

S-661 —To define child care centers to include private and public child care centers, day nurseries; nursery schools or other establishments of similar character; to define Local Child Development Council and to provide for a Child Development Committee in the Department of Education and other amendments. *APPROVED.*

S-666 —To provide that any person who knowingly possesses or sells drug paraphernalia evincing an intent to use the same for unlawfully mixing, compounding or otherwise preparing any narcotic drug or unlawfully manufacturing, packaging or dispensing of any narcotic drug is a disorderly person. *APPROVED*

S-686 —To grant physicians and surgeons immunity from liability for services rendered at the request of police where persons are suspected of operating a motor vehicle under the influence of liquor or drugs. *APPROVED*

S-712 —To authorize the Commissioner of Environmental Protection to limit the treatment and disposal within this State of solid waste collected outside the State. *APPROVED*

*S-714 —To establish regional evaluation centers for mentally retarded, physically handicapped, handicapped, emotionally disturbed, socially maladjusted, and multiple handicapped children and to appropriate $100,000. *APPROVED*

S-728 —To reduce from 0.15% to 0.10% the weight of alcohol in the defendant's blood which shall not give rise to any presumption of drunken driving and to repeal Section 2 of C. 141, P.L. 1966. (See A-719) *APPROVED*

S-739 —To prohibit an owner of a motor vehicle from permitting another person to operate such vehicle while impaired by the consumption of alcohol. *APPROVED*

S-754 —To prohibit use of any decorations, draperies or curtains of highly flammable materials in buildings of a public character. *APPROVED*

S-755 —To define and include toys under the act regulating sale, manufacture or distribution of highly flammable wearing apparel and fabrics. *APPROVED*

S-773 —To require the Department of Environmental Protection to prepare periodic reports on ambient air quality in various regions of the State and to distribute such reports to news media for publication and to appropriate $10,000. *APPROVED*

S-774 —To authorize the Department of Environmental Protection to prepare design standards for marine toilets installed in boats operating in waters of this State and to provide that no vessel shall be provided a certificate of number under the Boat Act unless equipped with a marine toilet approved by the Department. *APPROVED*

*S-779 —To repeal R.S. 2A:134-4 which relates to the polluting of waters used for ice harvesting. *APPROVED*

S-783 —To require persons who operate oil facilities to demonstrate to the Commissioner of Environmental Protection an ability to remove and contain any oil reasonably expected to be

discharged from such facility under the Oil Pollution Prevention Act of 1971. *APPROVED*

S-784 —To increase the membership of the Advisory Council on Solid Waste Management from 11 to 13 and to include thereon the Secretary of Agriculture and the Dean of the College of Agriculture and Environmental Science of Rutgers University. *APPROVED*

*S-789 —To provide that the implied warranties of merchantability and fitness under the Uniform Commercial Code shall not apply to contracts for sale of blood, blood plasma or human tissues or organs. *ACTIVE SUPPORT*

S-791 —To provide that no person employed by any school district shall use the designation of doctor unless such degree is an earned or honorary degree conferred by a college or university acceptable to the State Board of Examiners for certification purposes. *APPROVED*

S-817 —To establish a Department of Mental Health as a principal department of the State Government and to appropriate $100,000 therefor. *APPROVED*

S-830 —To increase membership on the State Board of Medical Examiners to 15 from 11, to provide the Governor power to appoint all members and to make all members full voting members. *APPROVED*

S-835 —To provide a pilot program of mandatory civil commitment of certain drug dependent persons in treatment centers, to prescribe procedures and to appropriate $1,500,000 therefor. *APPROVED*

S-839 —To require the New Jersey Turnpike Authority to prepare an environmental impact statement on each project, addition or extension to the New Jersey Turnpike before final approval of such project. *APPROVED*

S-841 —To create the New Jersey Health Care Facilities Financing Authority, define its powers and duties and to authorize the issuance of bonds and notes of the Authority. *APPROVED*

A-307 —To direct the acquisition of the Margaret Hague Maternity Hospital for $1 for use of the College of Medicine and Dentistry. (See A-767.) *DISAPPROVED*, because the college is primarily interested in education and should not become burdened with the administration and operation of state facilities not essential to that educational function.

A-416 —To eliminate the requirement for a post mortem examination where death occurs within 24 hours after admission to a hospital or institution. *APPROVED*

A-514 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *ACTION DEFERRED*, pending a conference with the sponsor of the bill.

A-646 —To provide for allocation of $.005 for each 10 cigarettes or fraction thereof for research into causes, prevention and cure of diseases associated with smoking. *ACTION DEFERRED*, pending reply from the College of Medicine and Dentistry of New Jersey.

A-647 —To increase the cigarette tax from 7 cents to 7.5 cents for each 10 cigarettes with the additional tax to be annually appropriated to the College of Medicine and Dentistry for research of causes, prevention, and cure of diseases associated with cigarette smoking. *ACTION DEFERRED*, pending reply from the College of Medicine and Dentistry of New Jersey.

*A-674 —To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist who operates only x-ray equipment for dental radiographs and only under the direct supervision of a licensed dentist; to provide for 9 examiners, in place of 10, on the x-ray technician board. *APPROVED*

A-699 —To provide that claims and reimbursement of physicians or psychologists shall not be denied for certain reasons under the act concerning group health insurance. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-700 —To provide for reimbursement of licensed psychologists for eligible services under the act concerning medical service corporations. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-701 —To provide for payment of services of psychologists under policies of health insurance provided by the act concerning the Life and Health Insurance Code whether the services are performed by a physician or a duly licensed psychologist. *DISAPPROVED*, because the bill is unnecessary, since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-719 —To provide that the presumption that a motor vehicle violation defendant was or was not under the influence of alcohol shall not arise where the alcohol content in a defendant's blood was in excess of .05% but less than 0.12%. (See S-728). *APPROVED*

A-731 —To exclude storm doors from the act regulating safety glazing material. *DISAPPROVED*, because storm doors constitute a grave and frequent hazard, especially to children.

Note: The Board changed the recommended position of "no action" to DISAPPROVED, for the reason given above.

*A-740 —To require labeling of food where appropriate "This article of food was frozen and permitted to thaw" by the retail place of business. *APPROVED*

A-757 —To provide that an act to cause miscarriage of the pregnant woman is justifiable when committed with her consent by a duly licensed physician acting within 24 weeks of the be-

ginning of the pregnancy or under a reasonable belief such is necessary to preserve her life. *DISAPPROVED,* because the bill is not compatible with the official position of The Medical Society of New Jersey, which declares:

. . . Recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any circumstances, The Medical Society of New Jersey is opposed to induced abortion except when:

(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

(3) There is documented medical evidence that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient,

(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing, and

(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals. . . . (Adopted 1968)

A-767 —To authorize and direct the Board of Trustees of the College of Medicine and Dentistry to purchase for use the Jersey City Medical Center for $1. (See A-307.) *DISAP-*APPROVED, because the College is primarily interested in education and should not be burdened with the administration and operation of state facilities not essential to that educational function.

*A-779 —To provide that the blind and otherwise physically disabled shall have the opportunity to public and private employment except where the disability prevents performance of work involved, and to obtain all public accommodations, publicly assisted housing and other real property without discrimination. *APPROVED*

A-780 —To provide for packaging of meat in transparent packages and limited labeling on one side. *APPROVED*

A-800 —To provide that firemen suffering disability or death from a respiratory disease shall be presumed to have been suffered in the performance of duty. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical evaluation.

A-809 —To make the effective date of the act regulating the use of safety glazing material December 30, 1972. *DISAPPROVED,* because the protective advantages of the new law should accrue to the public at the earliest possible date.

Note: The Board changed the recommended position of "no action" to *DISAPPROVED,* for the reason given above.

A-819 —To provide that the Board of Medical Examiners shall charge fees for licenses to practice medicine and surgery as provided for in the Statutes and where not so designated such fees shall be prescribed by rule or regulation. *ACTIVE OPPOSITION,* because the imposition of these fees, which are in excess of those applicable in other states, will tend to discourage young physicians from coming to New Jersey to practice.

Note: The Board changed the recommended position of "disapproved" to *ACTIVE OPPOSITION,* for the reason given above.

A-826 —To require the labeling of milk and milk products indicating the date beyond which the milk or milk product cannot be sold. *APPROVED*

A-827 —To establish a New Jersey Ocean Sanctuary under the care and control of the Department of Environmental Protection. *APPROVED*

A-832 —To permit freeholders in counties which have no county home or hospital for the diagnosis and care of children afflicted with Cooley's anemia to appropriate not more than $5,000 each year for such care. *APPROVED*

A-835 —To clarify certain sections of Noise Control Act of 1971 and eliminate veto power of the Noise Control Council. *NO ACTION*

A-837 —To require school buses transporting school children to be equipped with emergency exits including roof exits with the standards to be prescribed by regulations of the State Board of Education. *APPROVED*

A-838 —To provide that the rules and regulations of the State Board of Education for equipment on school buses shall include a requirement that the back of seats shall be 28 inches high and padded with energy absorbing load distribution materials and restraint systems for the drivers and passengers seats. *APPROVED*

A-851 —To permit the sending of handicapped children to special classes in schools of any other State of the United States. *NO ACTION*

A-862 —To authorize the Department of Health to establish a testing procedure for the detection of sickle cell anemia in children. *APPROVED*

A-869 —To authorize counties to establish County Environmental Protection Councils. *DISAPPROVED,* because it unnecessarily duplicates the powers already vested in the State Department of Environmental Protection.

A-870 —To provide for the regulation and registration of snowmobiles. *APPROVED*

A-871 —Provides for rewards for persons furnishing information leading to the arrest and conviction of certain controlled dangerous substances offenders; appropriates $100,000. *NO ACTION*

A-875 —To authorize boards of education concurred in by the county superintendent to transport pupils to school where unduly hazardous traffic conditions exist. *APPROVED*

A-882 —To require all vehicles transporting children

to school to observe all traffic safety laws applicable to school buses. *APPROVED*

A-904 —To permit qualified technical aides to perform limited medical procedures ordered by a a responsible licensed physician. *CONDITIONAL APPROVAL,* providing that the bill is amended to indicate that the physician directing the technical aide shall certify as to his or her competence.

A-908 —To amend the law concerning operation of a motor vehicle while under the influence of narcotics to conform to the New Jersey Controlled Dangerous Substances Act. *APPROVED*

A-914 —To revise penalties for polluting fresh or tidal waters of the State to fines of not more than $2,500 for the first offense and $10,000 for any subsequent offense. *APPROVED*

A-916 —To provide that disability or death of a policeman or fireman resulting from respiratory diseases shall be presumed to be job related. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical evaluation.

A-922 —To exempt certain non-prescription drugs from the sales tax. *NO ACTION*

A-925 —To provide that persons who illegally practice medicine or surgery shall be guilty of a misdemeanor. *APPROVED*

A-936 —To outlaw abortions unless necessary to preserve the life of the mother, which determination must be made by two physicians, and to define illegal abortion as a high misdemeanor. *DISAPPROVED,* because the bill is not compatible with the official position of The Medical Society of New Jersey, which declares:

> . . . Recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any cirmumstances. The Medical Society of New Jersey is opposed to induced abortion except when:
>
> (1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or
>
> (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or
>
> (3) There is documented medical evidence that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient,
>
> (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing, and
>
> (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals. . . . (Adopted 1968)

A-940 —To extend coverage of the "New Jersey Medical Assistance and Health Services Act" to recipients of general public assistance. *APPROVED*

A-944 —To prohibit storing or dumping materials in a manner that may degrade or threaten to degrade water quality resulting in damage to aquatic life and wildlife. *APPROVED*

A-952 —To amend the law prohibiting use of lead paint to prohibit certain additional uses and to provide a right of action and right to damages to persons affected. *APPROVED*

A-979 —To provide that graduates of foreign medical schools shall not be required to take examinations as a condition of beginning an internship or residency in any hospital of this State. *ACTIVE OPPOSITION,* because this legislation erroneously assumes that all foreign medical schools are the academic equal to American and Canadian medical schools. Its enactment would have a devastating effect on intern and residency training programs in New Jersey. The bill would lead to disaccreditation of those intern and residency training programs, and thus would discourage qualified medical school graduates from applying for training in this State.

Note: The Board changed the recommended position of "disapproved" to *ACTIVE OPPOSITION,* for the reason given above.

Guide for Medical Management of Child Abuse . . . Approved the following recommendation from the Council on Public Health:

That MSNJ send "A Guide for the Medical Management of Child Abuse" to each New Jersey hospital that maintains an emergency room.

(The brochure was prepared by MSNJ's Committee on Child Health, with the assistance of Dr. Phoebe Hudson of Bergen County and Mr. John Cosgove, Pediatric Social Worker at Martland Hospital.)

. . . Directed that a copy of the "Guide" be submitted for publication in *The Journal,* MSNJ. (See p. 551, this issue.)

RH and Blood Typing . . . Approved the following recommendation from the Committee on Maternal and Infant Welfare, which was approved by the Council on Public Health:

That the Board of Trustees inform the New Jersey Department of Health that The Medical Society of New Jersey requests performance of *routine* determinations of Rh factor and blood type for *all* pregnant females upon the order of their treating physicians and at State expense.

Hearing Screening in Public Schools . . . Approved the following recommendation from the Committee on Conservation of Vision,

Hearing and Speech, which was approved by the Council on Public Health:

That MSNJ give full support and cooperation to the State Department of Education in establishing legislation for the enforcement of screening of hearing in the public schools.

Finance and Budget Committee . . . Approved the report of the Committee on Finance and Budget, including recommendations to the 1972 House of Delegates. The entire report will be included in the Transactions Issue of *The Journal* (July) and is not preprinted here.

Medical Education . . . Approved the following recommendations from the Committee on Medical Education:

1. That the Committee on Medical Education be authorized to assume the duty of accrediting courses of continuing physician education in New Jersey in accordance with AMA guidelines and principles.

2. That the Committee on Medical Education be authorized to negotiate approval of MSNJ's accreditation plan with the AMA Council on Medical Education.

3. That in order to continue active membership in MSNJ, members must participate in approved programs of continuing education for a total of 150 hours in a given three-year period, *in accordance with AMA guidelines.* (A program accredited by either the AMA Council on Medical Education or MSNJ's Committee on Medical Education is acceptable.)

. . . Approved, as a means of emphasizing the position stated in the foregoing recommendation, the following resolution for introduction in the House of Delegates:

Whereas, continuing education for physicians is being increasingly acknowledged as requisite for the maintenance of professional capability and performance in the rendition of high quality medical care; and

Whereas, the American Medical Association has referred the responsibility for accrediting continuing medical education programs within state boundaries to state medical associations; and

Whereas, continuing medical education is being mandated in various areas of the country either by legislative enactment or state medical society requirement; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record itself as favoring the adoption of an added requirement for retention of membership; namely, that in order to continue active membership in MSNJ, members must participate in approved programs of continuing education for a total of 150 hours in a given three-year period, in accordance with AMA guidelines. (A program accredited by either the AMA Council on Medical Education or MSNJ's Committee on Medical Education is acceptable.)

Foundation Approach to Medical Care . . . Approved, as amended, the report of the April 1st meeting of the *Ad Hoc* Committee to Study and Make Recommendations Concerning the Foundation Approach to Medical Care, including the following recommendation:

That the Board of Trustees appoint a Steering Committee for the Foundation Approach to Medical Care whose duties will include *making recommendations to the Board of Trustees concerning:* (Italics indicate Board of Trustees' amendment.)

(a) Selection of a foundation plan

(b) Incorporation of the foundation plan as a nonprofit corporate body

(c) Adoption of a constitution and bylaws

(d) Consultations with the Health Insurance Council and Blue Cross and Blue Shield regarding underwriting administrative costs on a pro rata basis of the number of insurance policies written within the state

(e) Board membership—both medical and lay members

(f) A plan for the recruitment of physicians

. . . Directed that the responsibility for appointing the Steering Committee be given to the Executive Committee, with the stipulation that there be at least one member from each component society.

. . . Directed that, having completed its assigned task, the *Ad Hoc* Committee to Study and Make Recommendations Concerning the Foundation Approach to Medical Care be discharged, with thanks.

Ad Hoc Steering Committee for Continuing Medical Education . . . Received the following report from the Executive Director of a meeting of the above-named committee, held on March 28 with representatives of MSNJ, CMDNJ, the Academy of Medicine, the Directors of Medical Education, the New Jersey Association of Osteopathic Physicians, the State Department of Health, the State Department of Higher Education, and the Regional Medical Program:

The Steering Committee proposes that the New Jersey Office of Continuing Medical Education be formally established. The aims and objectives of this office would be:

(a) To assist community hospital medical staffs in developing continuing medical education activities.

(b) To utilize educational resources of the State to improve continuing medical education activities and develop educational skills.

(c) To coordinate educational activities with other programs of continuing medical education in the community, and the region in order to avoid duplication.

(d) To develop a system to provide a basis for accreditation of continuing medical education activities in the community hospital, which may be used to meet the standards and requirements of national and/or state policies.

(e) To develop mechanisms for the evaluation of the effectiveness of continuing medical education.

The Steering Committee further proposes the establishment of an Advisory Council made up of representatives of each of the participating groups.

The representatives approved the designation of James A. Rogers, M.D., as the Coordinator of the New Jersey Office of Continuing Medical Education, and the establishment of an Advisory Council.

Radiation Protection Fee Schedule . . . Noted that the President had sent a communication (under date of March 30), after receipt of a letter from the Essex County Medical Society expressing opposition to the "Proposed Rules Establishing the Radiation Protection Fee Schedule," to the Chief of the Bureau of Radiation Protection of the Department of Environmental Protection urging that the proposed radiation protection fee schedule be not adopted and suggesting that a public hearing be held before any other fee schedule is proposed.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during April 1972:

	1972 April	1971 April
Aseptic meningitis	4	11
Primary encephalitis	3	2
Hepatitis: Total	275	432
Infectious	221	334
Serum	54	98
Malaria: Total	2	13
Military	1	11
Civilian	1	2
Meningococcal meningitis		8
Mumps	104	317
German measles	289	191
Measles	61	262
Salmonella	62	77
Shigella	13	17

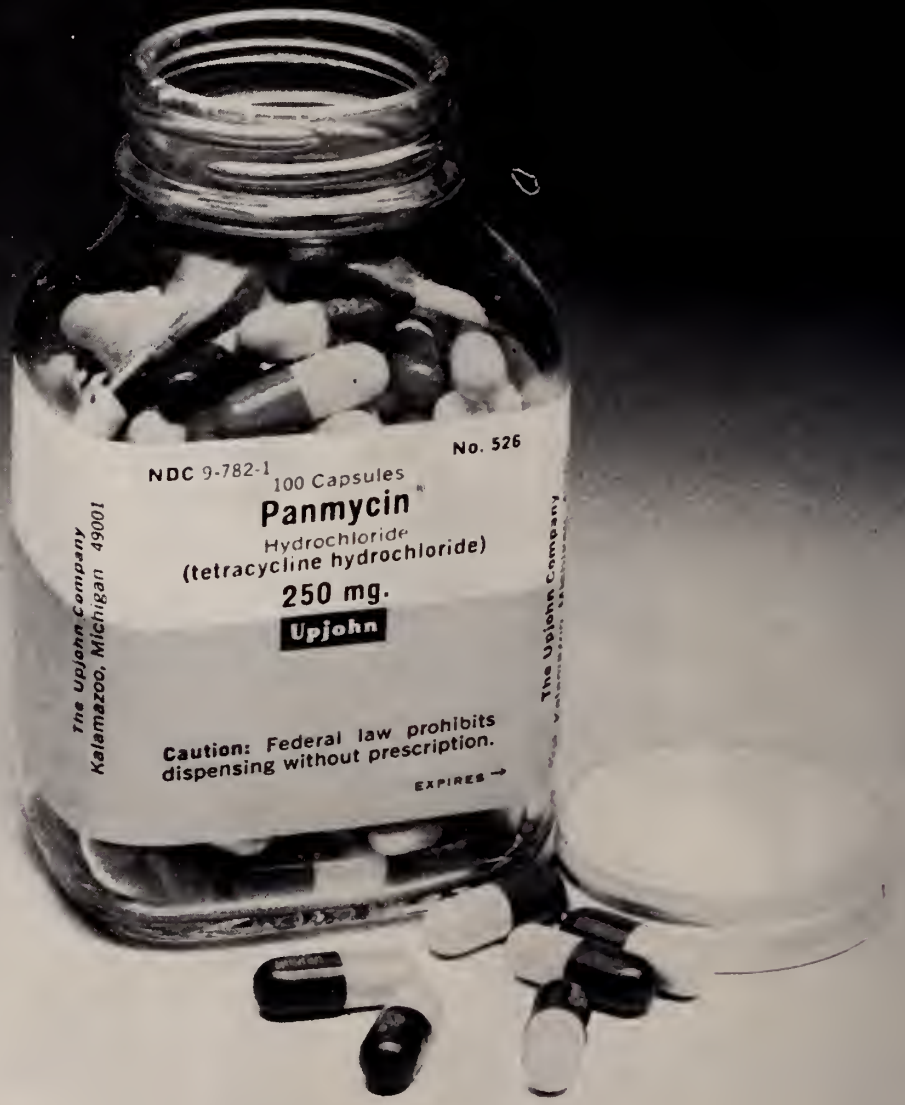
Smallpox

During March, 1972, a smallpox outbreak occurred in Yugoslavia. It began in the southwestern provinces of Kosovo, Macedonia, and Montenegro. Subsequently, smallpox was introduced into Belgrade by transfer of a patient there who had not been previously diagnosed as having smallpox. Currently morbidity and mortality figures are not available, but at the end of March there had been 140 cases.

This outbreak provided an early test of the recent change in U.S. smallpox vaccination policy. The procedures employed during the past month were as follows: Travelers arriving from Yugoslavia were identified at the point of entry. Names and addresses were forwarded to the state health department in the state where the person would be staying. In New Jersey the individual was placed under daily surveillance for fourteen days. A suspicious illness or rash was promptly investigated.

By mid April, the outbreak in Yugoslavia appeared to be waning. Travelers from the southwest provinces and those not previously vaccinated are still being put under daily surveillance. The only case reported from Yugoslavia appears to have been a Yugoslavian worker who developed smallpox while in West Germany. The diagnosis was promptly made and no secondary cases developed.

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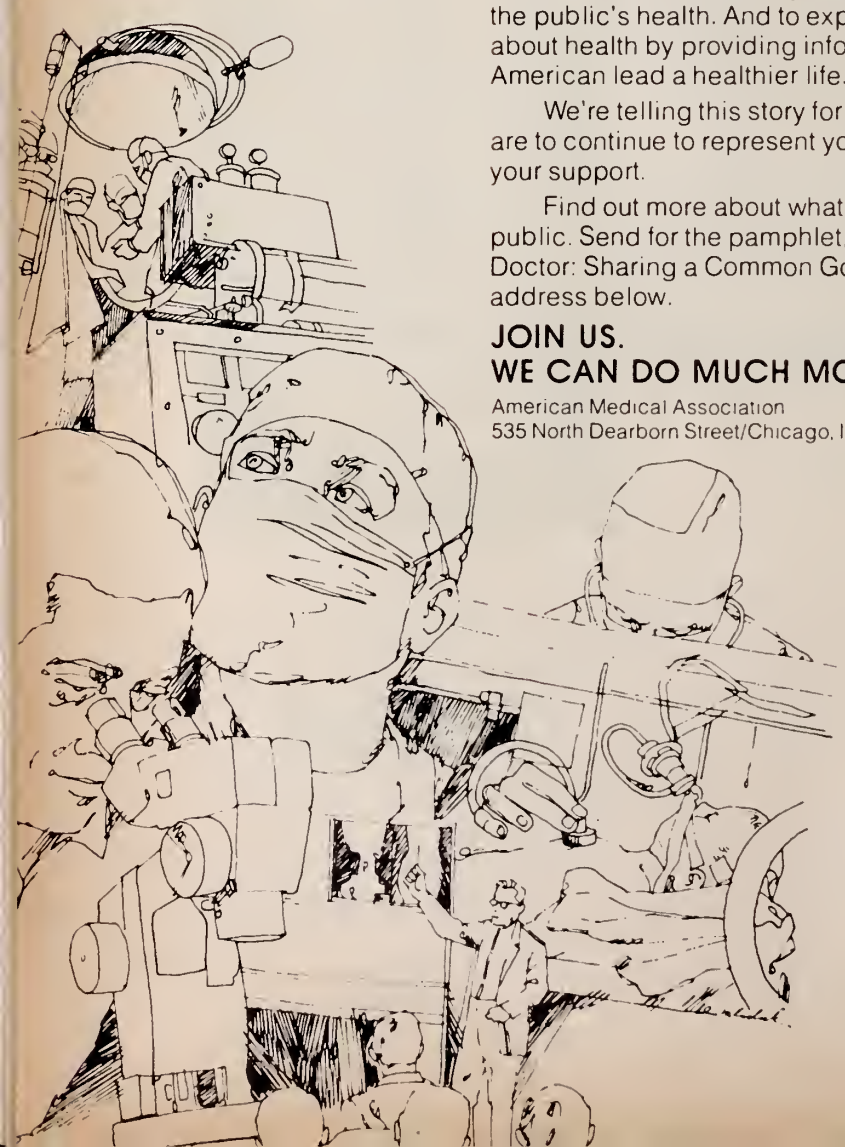
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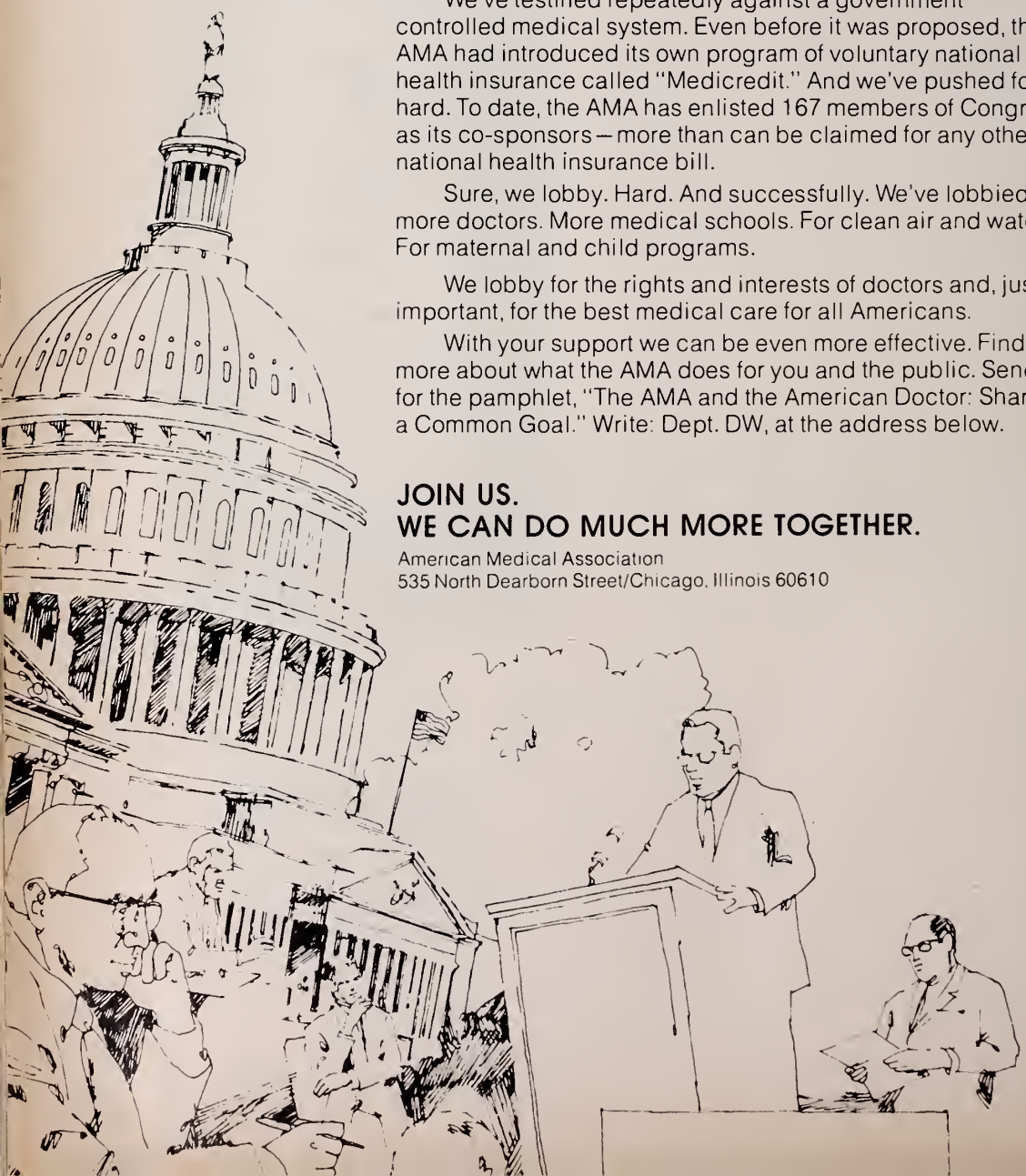
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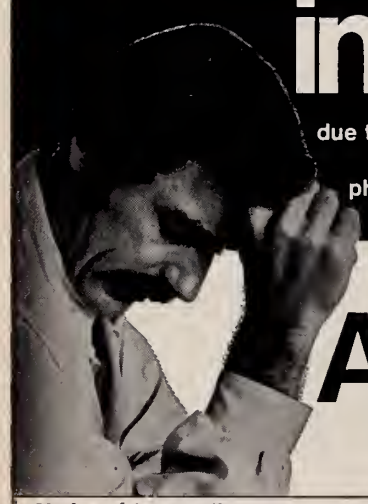
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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Thiamine HCL .....25 mg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evnon-Sinn, I. Methyltinolstrone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titoff, A. S. Methyltnstosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heiman, L., Gradiev, N. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 18:938, 1959. 5. Fnrris, E. J., and Coltne, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Ozal, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lipincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Medical College Notes

Stanley S. Bergen, Jr. M.D.
President, CMDNJ

In February of 1972, Harold Kaminetzky, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, New Jersey Medical School in Newark, assumed the additional responsibility as Acting Dean of that school. In this capacity, Dr. Kaminetzky will be assisted by Bernard Briody, Ph.D., Chairman of the Department of Microbiology, who will assume responsibility for academic programs and research activities of the basic sciences with the title of Acting Associate Dean, and John Mallams, M.D., who will continue as Associate Dean for Patient Services with responsibility and authority for the coordination of patient care activities at Martland Hospital. During his tenure at the Medical School, Dean Kaminetzky has received worldwide notice for the development of programs in urban health, particularly in the areas of maternal and infant care and family planning. Dr. Kaminetzky is responsible for one of the largest family planning programs in the country and his department has been noted for its continual interface with the community and community problems.

Rulon W. Rawson, M.D., the former Dean of the New Jersey Medical School has assumed responsibilities as Special Assistant to the President and will be involved in the development of research projects and special programs, with particular interest in the area of cancer research, detection, and treatment.

In March of 1972, Mr. Foster Burnett, former Assistant Dean at the Newark College of Arts and Sciences at Rutgers University was appointed Director of the Students for Medicine Program. In this capacity, Mr. Burnett will develop a program which aims to prepare students to meet successfully the academic and developmental requirements of a medical school curriculum. During its initial phase, this program will be limited to incoming members of the freshmen class at the two medical schools. However, in the future it is hoped that this program can be extended to undergraduate college students who have indicated an interest in the study of medicine.

John Landor, M.D., has joined the faculty of Rutgers Medical School as the Chief of General Surgery. Dr. Landor has recently been a member of the Surgical Department at the University of Florida. As Director of the Division of General Surgery, Dr. Landor joins three clinical chairmen on the faculty at Rutgers Medical School. They are James W. Mackenzie, M.D., Professor and Chairman, Department of Surgery, Hadley Conn, M.D., Professor and Chairman, Department of Medicine, and Irwin Pollack, M.D., Professor and Chairman, Department of Psychiatry.

Rutgers Medical School is moving rapidly to develop clinical departments, since in the fall of 1972 the school will carry students forward into the third year of curricular training. This will represent the first students to receive clinical instruction at Rutgers Medical School. Since its inception in 1965, this school has been a two year basic science school awarding the degree, Master of Medical Sciences.

Over the past few months a number of community hospitals have joined with Rutgers Medical School in the expectation of clinical training for our students. These institutions will provide the clinical resources for our third and fourth year training programs and eventually we expect some of our affiliated hospitals to participate in joint programs of graduate training for interns and residents. General affiliation contracts have been developed with the Hunterdon Medical Center in Flemington and Muhlenberg Hospital in Plainfield. The affiliation agreement with the Middlesex Hospital in New Brunswick is currently limited to surgery, while a similar agreement with Princeton Hospital in Princeton, includes surgery and medicine. These facilities will aid us in our efforts to expand the current college-wide enrollment of 800 students as we attempt to fulfill the medical and dental educational needs of the State of New Jersey.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—P. Cuni, M.D., 2620 SW 14th Street, Miami, Florida 33145. University of Havana 1957. Group, partnership, solo, institution. Available.

Vida C. Baron, M.D., 43 Bronx River Road, #6-0, Yonkers, New York 10704. Howard 1969. Board eligible. Solo, group, or salaried. Available July 1972.

Farooq Qureshi, M.D., 1136 Vine Street, Liverpool, New York 13088. King Edward (Pakistan) 1967. Board eligible. Group, partnership, solo, teaching. Available July 1972.

CARDIOLOGY—Robert F. Marvin, M.D., 1118-C John Street, Charlottesville, Virginia 22903. Temple 1965. Board certified in internal medicine. Group, partnership, or hospital. Available July 1972.

EMERGENCY ROOM—Hervey S. Sicherman, M.D., 414 Hayes Circle, Fort Ord, California 93941. Part-time surgery or general. Available October 1972.

GENERAL PRACTICE—Biagio Scialpi, M.D., 156 Caryl Avenue, Yonkers, New York 10705. University of Bari (Italy) 1949. Solo or partnership. Available July 1972.

INTERNAL MEDICINE—Stephen M. Druckman, M.D., 3910 Powelton Avenue, Philadelphia, Pennsylvania 19104. Jefferson 1967. Board eligible. Subspecialty, gastroenterology. Partnership or group. Available July 1972.

Manuel M. Liu, M.D., 655 East 14th Street, New York 10009. University of Philippines 1965. Board eligible. Subspecialty, chest diseases. Institution, group, or partnership. Available August 1972.

Robert Weitzman, M.D., 216 Thelma Terrace, Linden 07036. CMDNJ 1966. Board eligible. Subspecialty, pulmonary disease. Group or partnership. Available October 1972.

NEUROLOGY—Richard N. Selby, M.D., 1705 Spaatz Drive, CAFB, Rantoul, Illinois 61886. Downstate Medical 1962. Board eligible. Group, partnership, institution, or solo. Available September 1972.

OBSTETRICS/GYNECOLOGY—Mahpara Razzi, M.D., 4247 Orion Park, Liverpool, New York 13088. Osmania 1961. Board eligible. Group, partnership, or hospital. Available July 1972.

M. T. Shahab, M.D., 1764 Yorktown Road, Cincinnati, Ohio 45237. Tehran 1962. Board eligible. Group or partnership. Available September 1972.

OPHTHALMOLOGY—Kenette Kay Sohmer, M.D., Apt. 209, Knight House, Cooperstown, University of Kentucky, Lexington, Kentucky 40506. University of Kentucky 1968. Board eligible. Group, partnership, or solo. Available July 1972.

Gilbert B. Sussman, M.D., 16 Hopkins Road, Liverpool, New York 13088. Downstate Medical Center 1967. Group, partnership, or association. Available July 1972.

Edward J. Martin, M.D., 1024 New Scotland Road, Albany, New York 12208. NYU 1966. Board eligible. Partnership or solo. Available July 1972.

ORTHOPEDIC SURGERY—Stephen Dineberg, M.D., 4412A, USAF Academy, Colorado Springs, Colorado 80900. Hahnemann 1965. Board eligible. Partnership or solo. Available June 1972.

OTOLARYNGOLOGY—Stefan A. Kucinski, M.D., Newton Professional Center, Newton, Connecticut 06470. Warsaw (Poland) 1959. Board eligible. Solo. Available.

Stephen R. Geller, M.D., 3807 Pecan Street, Portsmouth, Virginia 23703. Chicago 1966. Board eligible. Group or partnership. Available July 1973.

PEDIATRICS—Sanford S. Epstein, M.D., 621 Empire Boulevard, Brooklyn, New York 11213. University of Bologna 1965. Board eligible. Group, partnership, or association. Available July 1972.

Noel M. Wiederhorn, M.D., 42-10 Golden Street, Flushing, New York 11355. New York Medical College 1969. Board eligible. Group or partnership. Available June or July 1972.

Jung-shung Wang, M.D., 401 Armstrong Avenue, Jersey City 07305. Taiwan 1963. Board eligible. Group partnership, or solo. Available July 1972.

SURGERY—Brian G. Miscall, M.D., 4214 Bethel Church Road, Columbia, South Carolina 29206. Cornell 1964. Board certified. Group, fulltime hospital, partnership. Available September 1972.

M. Fallahnejad, M.D., 5115 Wissahickon Avenue, A-26, Philadelphia, Pennsylvania 19144. Tehran 1961. Subspecialty, thoracic surgery. Board certified in both general and thoracic surgery. Group, partnership, or teaching. Available.

Vincent J. Begley, M.D., 25 River Road, C-26, Nutley 07110. New York Medical 1966. Board eligible. Solo or partnership. Available July 1972.

Sirous Arya, M.D., 79 Lincoln Boulevard, Kenmore, New York 14217. Tabriz (Iran) 1963. Board eligible. Group or partnership. Available July 1972.

Too Few Doctors?

"Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping smoking, and cutting down on alcohol than from having more physicians and hospitals to treat them after their bad habits laid them low."—Forum on National Health, Sun Valley, Idaho, June 1971

Solid Waste and the Doctor's Office

The following is a statement of the Special Committee on Environmental Health regarding our position on solid waste and plastic containers.

The present practice of the pharmaceutical industry in regard to medical samples suffers from gross over-packaging. Further, the rising use of plastic containers instead of glass has become an increasingly significant, totally unnecessary source of environmental stress and degradation. Plastics are all one-way containers requiring irreplaceable resources to make and returning only pollution (air and land) when they are disposed of.

The Committee urges members of the Society individually to bring this problem to the attention of every detail man who visits your office. Ask them to redesign their packaging to eliminate plastic containers and excessive packaging. The point can be driven home by refusing to accept over-packaged samples or displays. Ask the detail man to leave only the ungarnished product and to keep his displays and wads of packaging.

We urge all of you to take stock of the assorted pile of paper trash and rubbish that crosses your desk and into the wastebasket every day. If this disturbs you and wastes much of your time sorting through it, send a brief note to the senders of this promotional litter. Point out that you are aware of their product, and instead of wasting their money on promotion which only increases the cost of the medicine and your community's solid waste problem, it would make sense for all concerned to redirect the money saved on promotion into research or to reduce the cost of their product.

Physicians' Annual Registration

Under the provisions of Chapter 236 of the Laws of 1971, physician registrations for 1972-1973 are due by July 1, 1972. Applications for renewal of such registration were mailed June 1, 1972 to approximately 10,500 physicians who are currently registered. If you have not received an application, it is imperative that you contact the Board of Medical Examiners, 28 West State Street, Trenton 08625 (Phone—(609) 292-4843). Failure to do so may result in a monetary penalty and suspension of your license to practice medicine and surgery in this State.

Training for Emergency Physicians

The United States Public Health Service has made available an 83-page booklet concerning the training of physicians in hospital emergency departments. The material is based on a symposium sponsored by The Medical Society of New Jersey in cooperation with the New Jersey Department of Health. It covers such practical material as resuscitation of the seriously injured patient, managing the unconscious patient, treatment of burns, pediatric care, psychiatric emergencies, and the care of wounds. Copies of the booklet are available from the Division of Emergency Health Services, U. S. Public Health Services, 5600 Fishers Lane, Rockville, Maryland, 20852.

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ANNOUNCEMENTS

Summer Course in Sexuality

From July 16 to July 27 you may participate in a program of lectures, seminars, and group discussions on problems in sexuality. The fee of $325 includes housing. To register, write, before June 24, to the Summer Program, Institute for Sex Research, Indiana University, Bloomington, Indiana 47401.

Course in Allergy and Clinical Immunology

From July 17 through July 19, at the Plaza Hotel in Seattle, Washington, the American Association for Clinical Immunology and Allergy is offering an intensive course in current concepts in allergy and immunology. This will be preceded by a one-day business meeting of the Association.

Purpose of the course is to assist physicians in preparation for the forthcoming certification examination to be given by the new Conjoint Board in Allergy. A complete outline of the program and a synopsis of lectures will be given to each participating physician.

Through the efforts of Sidney Friedlander, M.D. (Detroit) and Bernard A. Berman, M.D. (Boston) an outstanding faculty has been assembled. For the full program and additional information, please write to the American Association for Clinical Immunology and Allergy, P.O. Box 912, DTS, Omaha, Nebraska 68101.

Support

The Society for Relief

of Widows and Orphans

Maternal and Child Health Programs

The Maternal and Child Health Program of the University of California at Berkeley announces graduate courses for pediatricians, obstetricians, and other physicians interested in receiving training in the field of maternal and child health. These programs all lead to the degree of Master of Public Health. *Tax-exempt* Fellowships are available, consisting of support for the trainee and his dependents, tuition, and fees. Applications are now being accepted for the group entering September 1973. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

Symposium on Crippled Children

The State Hospital for Crippled Children in Elizabethtown, Pennsylvania, is sponsoring an all-day meeting on Saturday, October 7, beginning at 9:30 a.m. There is no fee. Guest speakers include Albert Ferguson, Jr., M.D. —Dislocated Hip in Children; J. Leonard Goldner, M.D.—Congenital Hand Deformities and Club Feet in Children; and Anthony Bianco, M.D.—Spondylolisthesis and Femoral Fractures in Children. For further information, please write to Jerome M. Cotler, M.D., 193 West Commerce Street, Bridgeton, New Jersey 08302.

New Psychological Service

Announcement is made of the availability of *Psychological Growth Services*, a multidisciplinary professional group which provides diagnostic, evaluative, and psychotherapeutic services, including workshops and seminars. The directors of the program are Leonard Abramson, Ph.D., and Daniel Brower, Ph.D., both licensed practicing psychologists in New Jersey. The staff includes social workers, learning disability consultants, and art therapists. The Service is located at 345 Claremont Avenue, Montclair (201-783-4433).

LETTER TO THE JOURNAL

Against Compulsory Re-education

April 7, 1972

Dear Editor:

The April 6 issue of the *Newark Star Ledger* quotes Dr. Stanley Bergen as indicating that "for the first time in this State's history, practicing physicians would be required periodically to undergo refresher courses." It is suggested that this continuing education requirement could be enforced by medical societies or hospitals. Dr. Bergen "noted that The Medical Society of New Jersey was considering *requiring* its members to spend a certain number of hours in a three year period in continuing education."

I am personally on record as favoring periodic refresher courses. See my article in the November 1964 issue of *The Journal,* MSNJ, and the letter in this column in August 1970 from former president Cadmus and the then-dean Rawson. While I agree with Dr. Bergen about the wisdom of making graduate courses readily available, I disagree with him on the compulsory aspect of this program with its implication that you must take the courses or else! I challenge Dr. Bergen's pat thesis that the doctors lose 50 per cent of their knowledge every five years. I wonder how he collects and validates this neat figure. I object, too, to the bureaucratic entanglements that will develop in monitoring the sanctions imposed by this program. Doctors will have to pay whatever fees are required to take these courses—again a matter of pay or else! I wonder, too, if only GP's will have to go back to school, or whether the compulsion will be applied to proctologists, pediatricians, and plastic surgeons too. I wonder, finally, who will examine the examiners. As a profession we don't take kindly to compulsion and I think our professional society should come out in opposition to this kind of compulsion, even if this requires us to reverse a previous, somewhat more fashionable position.

Henry A. Brodkin, M.D.

OBITUARIES

Dr. Robert N. Bowen

One of the founding members of the American Academy of Obstetrics and Gynecology, Robert N. Bowen, M.D., died on March 28, 1972. Born in Iowa in 1911, he was a Hahnemann graduate, class of 1936. He had served as a trustee of the West Jersey Hospital in Camden for 15 years. Dr. Bowen was a captain in the Air Force during World War II. He was a Fellow of the American College of Surgeons, a Past-President of the New Jersey Chapter, and a Fellow of the American College of Obstetricians and Gynecologists. Dr. Bowen was active in the affairs of our Camden County Medical Society and also had a term of service as a member of the New Jersey State Board of Medical Examiners.

Dr. Robert A. Bradley

Born in 1895, Robert A. Bradley, M.D., a well-known Atlantic County radiologist, died on April 11, 1972. Dr. Bradley was a 1920 alumnus of the Jefferson Medical College. He was one of the pioneer radiologists of our State, and was, at one time, Vice President of the American Roentgen Ray Society. He had been chief radiologist at the Shore Memorial Hospital from 1930 to 1956 when he retired, and during that period he was also chief of the x-ray department at the Atlantic City Hospital. Dr. Bradley had a tour of duty as President of the Atlantic County Medical Society. He was a 1970 recipient of our Golden Merit Award.

Dr. Harry H. Capell

At the early age of 63, death came on March 20, 1972, to Harry H. Capell, M.D., a Passaic County practitioner who was widely known in the field of traumatic and industrial surgery. He was an associate in that field at both the Barnert Memorial and the Paterson General Hospitals. His M.D. degree came from Frankfurt in 1934. Dr. Capell belonged to the Industrial Medical Association of the United States and was a member of our Passaic County Medical Society.

Dr. Royal M. Cohen

One of Essex County's best known and most beloved members, Royal M. Cohen M.D., died on December 2, 1971, at the age of 85. He was a general practitioner of the kind usually characterized as a "family doctor of the old school." He was an emeritus member from our Essex County Medical Society. Most of his practice had been in the area of Montclair and the Oranges. He was a 1907 alumnus of the College of Physicians and Surgeons of Columbia University.

Dr. A. Dale Console

Dale Console was one of the few physicians who had been certified in both surgery and neurology-psychiatry. Born in 1914, he received his medical doctorate at Cornell in 1941. He practiced in New York and Princeton and belonged to our Mercer County Component Society. He had a five-year tour of duty as medical director of Squibbs. At the Pennsylvania Hospital, he had advanced training in neurosurgery. Dr. Console taught at his Alma Mater, and was the psychiatric consultant at Douglass College.

Dr. E. Gaylord Howell

A member of our Middlesex County Medical Society, E. Gaylord Howell, M.D., died on November 22, 1971, while attending a medical meeting. He was 73 years old at the time of his death. A Yale undergraduate, he entered Howard University Medical School in 1920 and received his M.D. degree in 1924. He had been on the staff of the Middlesex General Hospital. Dr. Howell was a member of the American Academy of Family Practice, and had been active in civic affairs, including the Urban League, the American Legion, and the NAACP. He was a Fellow of the American Geriatric Society.

Dr. Sidney C. Levine

Word has just been received of the death, on November 17, 1971, of Sidney C. Levine, M.D., an emeritus member from our Passaic County Medical Society. He was a urologist and for many years he had been on the staff of the Paterson General Hospital. Dr. Levine was a Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons. During World War I, he had been an officer of the Medical Corps of the Army of the United States. He was a 1966 laureate of our Golden Merit Award. Born in 1892, Dr. Levine was graduated from the Jefferson Medical College in 1916.

Dr. J. Julian P. Linke

At the 1972 annual meeting a Golden Merit award was given posthumously to J. Julian P. Linke, M.D., who died on April 10, 1972. He was 80 years old at the time of his death. Dr. Linke was a 1922 graduate of the Medical School of the University of Maryland. He was a member of our Union County Medical Society and for many years had been on the surgical service at the Muhlenberg Hospital in Plainfield. He was a Fellow of the American Association of Railway Surgeons.

Dr. Frank L. Lombardi

Born in 1909, Frank L. Lombardi, M.D., died on April 12, 1972, at the age of 63. He was a member of our Bergen County Medical Society and an alumnus of the New York Medical College, class of 1934. Dr. Lombardi had been health officer of the borough of Bergenfield, and was a general practitioner on the staffs of both Holy Name and Englewood Hospitals.

BOOK REVIEWS

Symposium on the Hand. Vol. 3. Lester M. Cramer and Robert A. Chase. St. Louis, Mosby, 1971. Pp. 287. Illustrated. ($35.75)

The original symposium which provided the material for this book took place in March, 1970, at Stanford University. Twenty-six authors contributed articles on this subject. Each author presents his own method for handling his topic. At the end of each chapter, a discussion is presented by other participants and members of the audience. This interesting dialogue presents differences of opinion or challenges some of the authors' statements.

Much of the material has been previously presented in medical journals. In most cases, this has been updated and in some cases represents a slight change in philosophy from the past.

Many authors here speak of the management of the proximal interphalangeal joint in various disease states with little duplication. Chapters three through eight deal with the problems of P.I.P. joint stiffness, synovectomy, post-traumatic recurvatum deformity, boutonniere deformity, joint stability, and reconstruction following burns.

Four chapters deal with the reconstruction of the rheumatoid hand. Niebauer and Swanson talk of implant arthroplasty and Zancolli offers an interesting chapter on his method of reconstructing ulnar drift.

A different technic of surgical management of Dupuytren's contracture is discussed by Gonzalez. Other chapters, of particular interest, concerned island flaps, hand reimplantation, and the rehabilitation of the hand in leprosy.

In general, the book is well written, easy to read, with ample illustrations which supplement the text. It should be of great interest to those surgeons who are dealing with these problems.

Jerome Spivack, M.D.

Care of the Geriatric Patient. (4th Edition) E. V. Cowdrey and Franz U. Steinberg, Editors. St. Louis, Mosby, 1971. Pp. 441. Illustrated. ($21)

The plan of this book is "for the internist to direct the medical care of geriatric patients in his own specialty and to refer them to specialists in other fields for advice on what they can do for patients beyond the internist's limited capacity." The editors recognize that treating illness alone is insufficient, particularly in geriatric patients who have special problems in other areas, including social situations, degenerative and neoplastic disease, altered appearance of disease processes in this age group, and special anesthesia on surgical considerations.

The book enlarges upon a geriatric symposium, to which other authors have been invited to make chapter contributions in their specialty. The material is up-to-date, drugs recommended include those recently made available, and surgical and laboratory technics are current. However, due to space limitations and the attempt to cover a wide field, the material is often in outline or condensed form. Partly to correct this deficiency, many authors have included a bibliography.

The material includes chapters on genetics, nutrition, sex, psychiatry, housing, community problems, neurology and care of the patient in the home, hospital, and nursing home settings. Some newer surgical methods are included. These are helpful to the physician in evaluating and advising corrective procedures.

Because this book assumes that multiple specialists will become involved in the care of the average geriatric patient, the information is somewhat superficial, for the most part, limiting the usefulness of the book to the primary care physician. The editors do not recognize that this may be the generalist or family physician, in most cases.

Joseph Peyser, M.D.

Review of Physiologic Chemistry, Edition 13. Harold A. Harper, Ph.D. Los Altos, California, Lange, 1971, Pp. 529. Illustrated. (Softback, $8.00)

This *Physiologic Chemistry* has been in print since 1939 and has gone through 13 editions. This itself is sufficient accolade for any volume, since, obviously, a text which has been that popular for that length of time must be meeting a need. As a matter of fact, physiologic chemistry is a much neglected branch of medical science and as here presented the book covers those phases of chemistry which are concerned with the background of medical illness and the physiology and treatment of disease.

Henry A. Davidson, M.D.

Hazards of Medication: A Manual on Drug Interactions, Incompatibilities, Contraindications, and Adverse Effects. Eric W. Martin, Stewart F. Alexander, Donald J. Farage, William E. Hassan, Jr., and Ruth D. Martin, Editors. Pp. 895. Philadelphia, Lippincott, 1971. ($27.50)

This 895 page manual contains much more than one would infer from the subtitle. Its value is much greater than the substantial usefulness of its major tables, in which are collated the myriad data needed in evaluating laboratory results and in avoiding adverse drug reactions.

The first composite table, blue in color and 47 pages long, is of interferences in clinical laboratory testing. Tabulated here are tests and the conditions detected by them, normal values and the significance of abnormal values, and causes of false-positive or elevated values and of false-negative or decreased values.

The next major table, green in color and 411 pages long, is of drug interactions, organized and cross-referenced by primary agent, interactant, and possible interaction.

In addition to these invaluable major tables (among a total of 55 tables), are chapters containing authoritative analyses and background information on factors affecting pharmacotherapy introduced through research and development, manufacturing, distribution, storage, prescribing practices, and patient responses.

Having used, reviewed, and browsed through this volume, I feel it is now a mandatory supplement to a basic pharmacology reference in any doctor's library.

Hyman W. Fisher, M.D.

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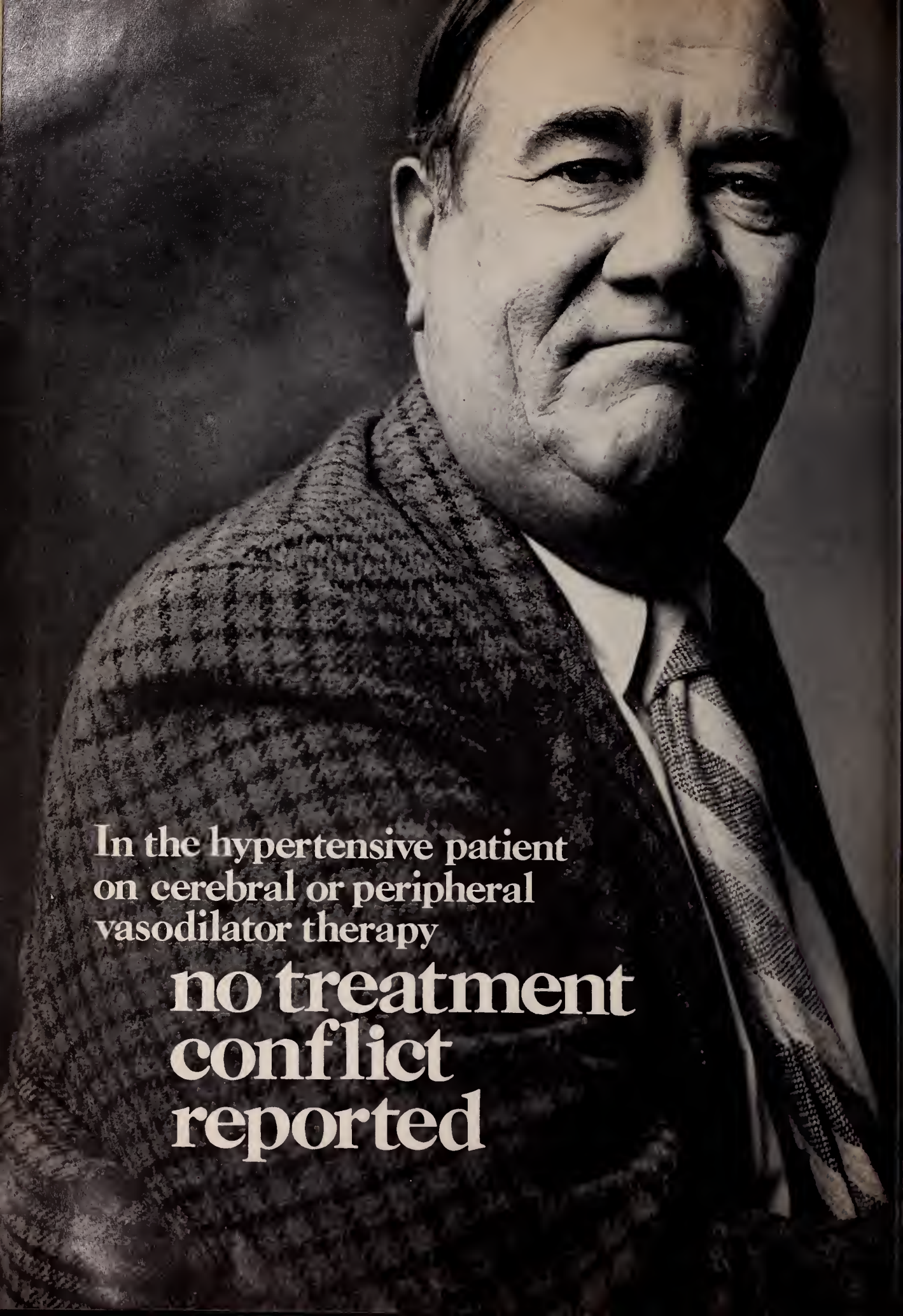
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References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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